Physician Services

Medicine and Surgery

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m. - 5:00 p.m. (M-F)

* Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

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Preface

The Wisconsin Medicaid and BadgerCare Physician Services Handbook is issued to physicians, physician assistants, physician clinics, nurse practitioners, nurse midwives, rural health clinics, and federally qualified health centers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid and BadgerCare publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Recipient Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Physician Services Handbook consists of the following sections:

- Medicine and Surgery.
- Laboratory and Radiology.
- Anesthesia.

In addition to the Physician Services Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 — Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Department of Health and Family Services, Chapters HFS 101-108.

Handbooks and *Wisconsin Medicaid and BadgerCare Updates* further interpret and implement these laws and regulations. Handbooks and *Updates* organized by provider type, maximum allowable fee schedules, helpful telephone numbers and addresses, Remittance and Status messages, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/
www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

General Information

The Medicine and Surgery section of the Physician Services Handbook includes information regarding covered services, reimbursement methodology, and billing information that applies to fee-for-service Medicaid providers.

What Are Medicaid-Covered Physician Services?

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

Physician services covered by Wisconsin Medicaid are:

- Diagnostic services.
- Preventive services.
- Therapeutic services.
- Rehabilitative services.
- Palliative services.

Wisconsin Medicaid reimburses only for those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost effective.

Refer to HFS 107.03 and to HFS 107.06(5), Wis. Admin. Code, for services ***not covered*** by Wisconsin Medicaid. Refer to the Covered and Noncovered Services section of the All-Provider Handbook for a partial list of the noncovered services.

Provider Eligibility and Certification

Physicians and Residents

To be certified by Wisconsin Medicaid, ***physicians and residents*** must be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14, Wis. Admin. Code.

Physicians are asked to identify their practice specialty at the time of Medicaid certification. Reimbursement for certain services is limited to providers with specific specialties.

Physicians who perform substance abuse (alcohol and other drug abuse), psychotherapy, dental, vision services, or physician's who dispense drugs should obtain the appropriate provider publications. Refer to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for a list of published materials for each Medicaid provider type. All the publications may be downloaded.

Physicians who wish to be reimbursed for psychotherapy services (*Current Procedural Terminology* codes 90801-90857, 90865-90899) must be certified as a psychiatrist pursuant to HFS 105.22(1)(a), Wis. Admin. Code. Any Medicaid-certified physician may be reimbursed for substance abuse services.

Physician Assistants

To be certified with Wisconsin Medicaid, ***physician assistants*** must be licensed and registered pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 8 and 14, Wis. Admin. Code. All physician assistants must be individually certified by Wisconsin Medicaid for their services to be reimbursed.

HealthCheck Certification

HealthCheck is Wisconsin Medicaid's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (see 42 CFR Parts 441.56 - 441.62). HealthCheck consists of a comprehensive health screening of Wisconsin Medicaid recipients under age 21. The screening includes review of growth and development, identification of potential physical or developmental problems,

preventive health education, and referral assistance to appropriate providers.

All physicians who are Wisconsin Medicaid certified with a specialty of family practice, general practice, internal medicine, or pediatrics are automatically certified as HealthCheck providers at the time of initial Wisconsin Medicaid certification. Physicians with other specialties who are interested in becoming HealthCheck providers should write to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Presumptive Eligibility

Physicians may become Medicaid-certified presumptive eligibility providers. Presumptive eligibility providers determine if a pregnant woman may be eligible for Wisconsin Medicaid. Presumptive eligibility allows a pregnant woman to obtain Medicaid-covered ambulatory prenatal services while waiting for a determination on her Medicaid application by a county/tribal social or human services department or W-2 agency. Refer to the Guide to Determining Presumptive Eligibility for Pregnant Women for more information on presumptive eligibility.

Physicians interested in being certified to make presumptive eligibility determinations for pregnant women may call Provider Services at (800) 947-9627 or (608) 221-9883, or write to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Prenatal Care Coordination Certification

The purposes of prenatal care coordination (PNCC) services are to help pregnant women identified as being at high risk for negative birth outcomes to gain access to, coordinate, and follow up on necessary medical, social, educational, and other services.

Physicians interested in becoming PNCC providers may call Provider Services at (800) 947-9627 or (608) 221-9883, or write to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Types of Provider Numbers

Wisconsin Medicaid issues all providers, whether individuals, agencies, or institutions, an eight-digit provider number to bill Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for a Medicaid-certified provider to bill using a provider number belonging to another Medicaid-certified provider.

Wisconsin Medicaid issues all providers, whether individuals, agencies, or institutions, an eight-digit provider number to bill Wisconsin Medicaid for services provided to eligible Medicaid recipients.

A provider keeps the same provider number in the event that he or she relocates, changes specialties, or voluntarily withdraws from Wisconsin Medicaid and later chooses to be reinstated. (Notify Provider Maintenance of changes in location or of specialty by using the Wisconsin Medicaid Provider Change of Address or Status form, HCF 1181, which may be obtained from the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* or by calling Provider Services at (800) 947-9627 or (608) 221-9883.) A provider's identification number is not reissued to another provider in the event of termination from Wisconsin Medicaid.

Wisconsin Medicaid issues three types of provider numbers to physicians, physician assistants, and physician clinics. Each type of provider number has its designated uses and restrictions. The three types are:

- Billing/performing provider number.
- Group billing number.
- Nonbilling/performing provider number.

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Billing/Performing Provider Number (Issued to Physicians and Residents)

Wisconsin Medicaid issues a billing/performing provider number to physicians and residents that allows them to identify themselves on the CMS 1500 claim form as either the biller of services or the performer of services when a clinic or group is submitting claims for the services.

Group Billing Number (Issued to Clinics)

A group billing number is primarily an accounting convenience. A physician clinic or group using a group billing number receives one reimbursement and one Remittance and Status (R/S) Report for covered services performed by individual providers within the clinic or group.

Individual providers within a physician clinic or physician group must also be Medicaid-certified because physician clinics and groups are required to identify the performer of the service on the claim form. (The performing provider's Medicaid provider number must be indicated in Element 24K of the CMS 1500 claim form when a group billing number is indicated in Element 33.) Ordinarily, a claim billed with only a group billing number is denied reimbursement. Refer to the CMS 1500 claim form completion instructions in Appendix 4 of this section for more information.

Nonbilling/Performing Provider Number (Issued to Physician Assistants)

Wisconsin Medicaid issues a nonbilling/performing provider number to physician assistants because they must practice under the professional supervision of a physician to be eligible providers. Physician assistants must be supervised by a physician to the extent required under state regulation and licensing statutes, medical practices statutes, and Med 8, Wis. Admin. Code. A nonbilling/performing provider number may not be used to independently bill Wisconsin Medicaid and is used in one of two ways:

1. If the claim is to be paid to the supervising physician, enter the physician assistant's nonbilling/performing provider number in Element 24K and the supervising physician's name and provider number in Element 33 of the CMS 1500 claim form.
2. If the claim is to be paid to the clinic, enter the physician assistant's number in Element 24K and the clinic's name and number in Element 33 of the CMS 1500 claim form.

Recipient Eligibility

Eligibility for Wisconsin Medicaid

Wisconsin Medicaid providers should ***always*** verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Recipients in the following benefit categories have limitations in their Medicaid coverage:

- Qualified Medicare Beneficiary only (QMB only).
- Specified-Low Income Medicare Beneficiary only.
- Qualified Working Disabled Individual.
- Presumptive eligibility for pregnant women.

- Illegal (undocumented) aliens. (The Provider Certification of Emergency for Undocumented Aliens form, Appendix 31 of this section, may be used when providing emergency services to undocumented aliens.)
- Tuberculosis (TB)-related.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about these restricted benefit categories and other eligibility issues, such as Lock-In status.

Eligibility information for specific recipients is available from Wisconsin Medicaid's Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient is enrolled in a Medicaid HMO, has commercial health insurance coverage, or is in a restricted benefit category. Providers can access Medicaid's EVS a number of ways, including:

- Automated Voice Response system.
- Magnetic stripe card readers.
- Personal computer software.
- Provider Services.
- Direct Information Access Line with Updates for Providers.

Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility. For more information about recipient eligibility itself, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.

Tuberculosis Benefit

All Medicaid-certified physicians and physician assistants are eligible to perform TB-related services. Wisconsin Medicaid covers individuals infected with TB or who have the active disease and meet financial eligibility requirements. This group of recipients is eligible for Medicaid-covered TB-related outpatient services *only*.

Tuberculosis-related outpatient services include:

- Tuberculosis-related drugs.
- Physician and clinic services.
- Laboratory and X-ray services — including services to diagnose and confirm TB infection.
- Transportation services.

Refer to the Guide to the Tuberculosis-Related Services Only Benefit for more information about TB-related services.

Medicaid Managed Care Coverage

Claims submitted to fee-for-service Medicaid for services covered by the recipient's Medicaid managed care program are denied. Additional information regarding the Medicaid managed care program noncovered services, emergency services, and hospitalizations is located in the *Wisconsin Medicaid Managed Care Guide* and in the Covered and Noncovered Services section of the All-Provider Handbook. Call Provider Services at (800) 947-9627 or (608) 221-9883 to order a copy of the *Wisconsin Medicaid Managed Care Guide*.

Claims submitted to fee-for-service Medicaid for services covered by the recipient's Medicaid managed care program are denied.

Recipient Copayment

A recipient's copayment is limited to $30.00 cumulative, per physician ***or*** clinic (using a group billing number), per calendar year.

Copayment Amounts

Copayment amounts are determined per procedure code per date of service as follows:

Copayment Amounts*	
Evaluation and management services (each office visit, hospital admission, or consultation):	
Maximum allowable fee	*Copayment*
• Up to $10.00	$0.50
• From $10.01 to $25.00	$1.00
• From $25.01 to $50.00	$2.00
• Over $50.00	$3.00
Surgery services (each)	$3.00
Diagnostic services (each) Allergy testing (per date of service)	$2.00

*Copayment amounts are based on the maximum allowable fee for each procedure code.

Maximum allowable fee schedules list the maximum amounts that Wisconsin Medicaid will reimburse providers for each procedure. The maximum allowable fee amount determines the copayment amount providers may request from a recipient. Options for obtaining a Physician Services Maximum Allowable Fee Schedule are listed in the Billing and Reimbursement chapter of this section.

Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on copayment requirements.

Copayment Maximum

A recipient's copayment is limited to $30.00 cumulative, per physician ***or*** clinic (using a group billing number), per calendar year.

Copayment Exemptions

According to HFS 104.01(12)(a), Wis. Admin. Code, providers are prohibited from requesting copayment from the following recipient groups:

- Children under 18 years old.
- People in nursing homes.
- People in state-contracted or other Medicaid managed care programs receiving managed care covered services. Refer to the *Wisconsin Medicaid Managed Care Guide* for more information on services not covered by managed care programs.
- Pregnant women who receive medical services related to their pregnancy or to another medical condition that may complicate their pregnancy.

The following services are exempt from copayments:

- Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
- Family planning services and supplies.
- Common carrier transportation, if provided through or paid for by a county/tribal social or human services department.
- Home health services.
- Injections and immunizations.
- Personal care services.
- Case management services.
- Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.
- Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy, whichever occurs first, during one calendar year.
- Hospice care services.
- Substance abuse day treatment services.
- Respiratory care for ventilator-assisted recipients.
- Community support program services.
- Specialized medical vehicle services.

Copayment and Billed Amounts

Wisconsin Medicaid automatically deducts the applicable copayment amount from the reimbursement allowed by Wisconsin Medicaid. Do not reduce the billed amount on the claim by the amount of recipient copayment. This amount is indicated on the provider's R/S Report.

Refund of Recipient Copayment

In the event that medical services are covered by a third party, including a commercial HMO, and the provider collects Medicaid copayment from a recipient, it is the provider's responsibility, not the responsibility of Wisconsin Medicaid, to refund the copayment amount to the recipient.

Coordination of Benefits

Health Insurance Coverage

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under commercial health insurance, Wisconsin Medicaid reimburses that portion of the allowable cost remaining after commercial health insurance sources have been exhausted. Wisconsin Medicaid will reimburse providers either the billed amount or the maximum allowable fee, whichever is less.

In some cases, Wisconsin Medicaid is the primary payer and must be billed *first*. Payers secondary to Wisconsin Medicaid include governmental programs such as:

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance (GA).
- Title V of the Social Security Act, Maternal and Child Health Services, relating to the Program for Children with Special Health Care Needs.
- The Wisconsin Adult Cystic Fibrosis Program.
- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring health insurance billing, exceptions, the Other Coverage Discrepancy Report, and payers secondary to Wisconsin Medicaid.

Medicare Coverage

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be submitted to Medicare prior to Wisconsin Medicaid.

Wisconsin Medicaid requires physicians and physician assistants to be Medicare certified to provide services to dual entitlees. Physicians and physician assistants not certified by Medicare are required to be retroactively certified by Medicare for the date and the service provided if they held a valid license when the service was provided.

Providers must accept assignment from Medicare for claims for dual entitlees. The dual entitlee is not liable for Medicare's coinsurance or deductible.

Usually, ***Medicare-allowed*** claims (called crossover claims) are automatically forwarded by the Medicare claims processor to Wisconsin Medicaid for processing. Wisconsin Medicaid reimburses the provider for coinsurance and deductible within certain limits described in the Coordination of Benefits section of the All-Provider Handbook. Wisconsin Medicaid reimburses providers for coinsurance and deductible on crossover claims even if the service provided was not a Medicaid-covered service.

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Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees.

If the service provided to a dual entitlee is covered by Medicare (in at least some situations), but ***Medicare denied*** the claim, providers should submit a new claim to Wisconsin Medicaid and indicate the appropriate Medicare disclaimer code in Element 11 of the CMS 1500 claim form. Refer to Appendix 4 (Element 11) of this section for a list of Medicare disclaimer codes.

For more information regarding HealthCheck "Other Services," including the appropriate PA attachment to submit, call Provider Services at (800) 947-9627 or (608) 221-9883.

Qualified Medicare Beneficiary Only

Qualified Medicare Beneficiary-Only recipients are eligible ***only*** for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-allowed services. Wisconsin Medicaid does not reimburse providers for services for QMB-only recipients that Medicare does not allow. Physicians must accept assignment from Medicare for claims for QMB-only recipients.

HealthCheck "Other Services"

Wisconsin Medicaid reimburses comprehensive health screenings for Medicaid recipients under age 21 through the HealthCheck program. If the screening indicates the need for a medically necessary physician service that is not ordinarily considered a covered service, Wisconsin Medicaid will consider the service for reimbursement as a HealthCheck "Other Service."

To be considered for reimbursement, the following conditions must be met:

1. The provider verifies that a comprehensive HealthCheck screening has been performed within the previous 365 days.
2. The service is allowed under Title XIX of the Social Security Act as a "medical service."
3. The service is "medically necessary" and "reasonable" to correct or ameliorate a condition or defect which is verified during a HealthCheck screen.
4. Services currently covered by Wisconsin Medicaid are not considered acceptable to treat the identified condition.
5. The service is prior authorized by Wisconsin Medicaid, except for certain over-the-counter drugs identified in the Pharmacy Services Handbook.

Prior Authorization Procedures for HealthCheck "Other Services"

The following guidelines are for obtaining prior authorization (PA) for HealthCheck "Other Services":

- Prior authorization documentation must include a completed Prior Authorization Request Form (PA/RF) which indicates the procedure(s) requested. (A procedure code need not be indicated on the PA/RF, since the Medicaid medical consultant assigns a code to any approved request.)
- Omit the type of service information from the PA/RF if it cannot be identified.
- Write "HealthCheck Other Services" in red ink on the top of the PA/RF to facilitate processing.
- Attach to the PA/RF the PA attachment that is most appropriate for the procedure(s) requested. For example, submit the Prior Authorization Physician Attachment (PA/PA) if the procedure requested is a physician service. The medical necessity for the procedure(s) must be documented in the attachment.
- Include in the documentation evidence that a comprehensive HealthCheck screening was performed within the last 365 days.

For more information regarding HealthCheck "Other Services," including the appropriate PA attachment to submit, call Provider Services at (800) 947-9627 or (608) 221-9883.

Prior Authorization

For general PA policies, refer to the Prior Authorization section of the All-Provider Handbook.

When is Prior Authorization Required?

Prior authorization must be obtained before providing services which require PA. Refer to Appendix 12 of this section for a list of physician services requiring PA.

Medicaid services requiring PA are reimbursable when all of the following criteria are met:

- The PA request is approved.
- The recipient is Medicaid eligible at the time the service is performed.
- The service is performed during the time period approved on the PA.
- The claim is completed correctly and submitted for reimbursement in a timely manner.
- The service is medically necessary, appropriate, and consistent with Medicaid reimbursement policy and billing requirements.

If Medicare or other health insurance is liable for coverage of a service which requires PA from Wisconsin Medicaid, the provider is strongly encouraged to obtain PA for Medicaid-eligible recipients. Without approved PA, Wisconsin Medicaid will not reimburse the portion of the claim that Medicare does not allow or that health insurance does not pay.

Why is Prior Authorization Required?

Wisconsin Medicaid requires PA for selected services to:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are usable.
- Curtail misutilization practices of providers and recipients.

Prior Authorization Forms

Physicians should use the following Wisconsin Medicaid forms for requesting PA:

- Prior Authorization Request Form (PA/RF).
- Prior Authorization Physician Attachment (PA/PA).
- Prior Authorization "J" Code Attachment (PA/JCA).
- Prior Authorization Request Form Physician Otological Report (PA/POR).

The PA/RF functions as a cover sheet and asks for general information regarding the provider, the recipient, and the service(s) for which PA is being requested.

The purpose of the PA/PA and PA/JCA is to document the medical necessity of the service(s). Use the PA/JCA for Health Care Procedure Coding System, formerly HCFA Common Procedure Coding System, "J" procedure codes requiring PA and use the PA/PA for all other physician services requiring PA.

The PA/POR begins the process by which a recipient obtains a hearing aid. The physician or physician assistant is to give the completed form to the recipient. The recipient then takes the PA/POR to any Medicaid-certified hearing instrument specialist to receive a hearing instrument.

Examples of the PA/RF, PA/PA, PA/JCA, and PA/POR and their completion instructions are included in Appendices 13 through 21 of this section.

M Medicare or other health insurance is liable for coverage of a service which requires PA from Wisconsin Medicaid, the provider is strongly encouraged to obtain PA for Medicaid-eligible recipients.

Providers may obtain PA forms by writing to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Please indicate the form(s) requested and the number of forms desired. Reorder forms that may be used for the next order are included with delivery.

Refer to Appendix 22 of this section for more information about faxing PA requests.

Submitting Prior Authorization Forms

Submit completed PA/RF, PA/PA, and PA/JCA forms to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers also have the option of submitting PA requests by fax at (608) 221-8616. Refer to Appendix 22 of this section for more information about faxing PA requests.

Experimental Services

Wisconsin Medicaid does not reimburse providers for services that are considered to be experimental in nature. A service is considered experimental when the Division of Health Care Financing (DHCF) determines that the procedure or service is not generally recognized by the professional medical community as effective or proven for the condition for which it is being used.

A service may be considered by the DHCF to be experimental in one setting or institution, but effective, proven, and nonexperimental in another depending on the experience, quality, and procedures used by a given institution.

The DHCF resolves questions relative to the experimental or nonexperimental nature of a procedure based on the following, as appropriate:

- The judgement of the medical community.
- The extent to which Medicare and commercial health insurers recognize and cover a service.
- The current judgement of experts in the applicable medical specialty area.
- The judgement of the Medical Assistance Medical Audit Committee of the Wisconsin Medical Society.

Evaluation and Management Services

Evaluation and management (E&M) services include office visits, hospital visits, and consultations. Specific services include examinations, evaluations, treatments, preventive pediatric and adult health supervision, and similar medical services.

Wisconsin Medicaid covers most of the categories of E&M services described in *Current Procedural Terminology* (CPT). Refer to Appendix 1 of this section for E&M procedure codes that Wisconsin Medicaid covers. Wisconsin Medicaid does ***not*** cover procedure codes in the following CPT categories:

Wisconsin Medicaid covers most of the categories of E&M services described in *Current Procedural Terminology* (CPT).

- Prolonged Physician Service Without Direct Patient Contact.
- Case Management Services.
- Care Plan Oversight Services.
- Counseling and/or Risk Factor Reduction Intervention.
- Special E&M Services.

Annual Physicals

Wisconsin Medicaid reimburses a maximum of one comprehensive, routine physical examination per calendar year per recipient. Recipients may use this examination to fulfill employment, school entrance, or sports participation requirements.

Concurrent Care

Wisconsin Medicaid covers E&M services provided on the same date of service (DOS) by two or more physicians to a recipient during an inpatient hospital or nursing home stay only when medical necessity is documented in the recipient's medical record.

Consultations

Physician E&M consultations are reimbursed by Wisconsin Medicaid when provided to a recipient at the request of another provider or when medically necessary and appropriate. Consultations are not covered when the recipient is an established patient of the provider billing the consultation. If a consultant assumes responsibility for management of the patient, the use of consultation procedure codes is no longer appropriate.

Covered Consultations

An E&M consultation requires face-to-face contact between the consultant and the recipient. A consultation must always include a written report which becomes a part of the recipient's permanent medical record.

When submitting a claim for a consultation procedure code, indicate the referring provider's name in Element 17 and his or her Medicaid provider number in Element 17a of the CMS 1500 claim form.

Critical Care and Prolonged Services

Wisconsin Medicaid reimburses providers for up to four hours per DOS of critical care (CPT procedure codes 99291-99292) and prolonged services (CPT procedure codes 99354-99357 and 99360) on an initial claim.

To request reimbursement for time in excess of four hours per DOS, providers are required to submit an adjustment request with documentation such as a history and physical exam report or a medical progress note) that identifies why services in excess of four hours should be covered. Providers may refer to the Claims Submission section of the All-Provider Handbook for a copy of the Adjustment

Request Form. The All-Provider Handbook may be found on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Wisconsin Medicaid only covers prolonged care CPT procedure codes 99354-99357 if there is face-to-face contact between the provider and the recipient. *Current Procedural Terminology* procedure codes 99358 and 99359 (prolonged care without face-to-face contact) are not covered services under Wisconsin Medicaid.

Ambulance Services

Critical care services provided by physicians in an air or ground ambulance are reimbursed under either critical care or prolonged care procedure codes. Physicians submitting claims for services provided in an ambulance must also attach to the claim a copy of the physician's clinical record.

Wisconsin Medicaid does not reimburse physicians for supervising from the home base of a hospital's emergency transportation unit or for supervising in the ambulance.

Emergency Department Services

When an emergency department E&M claim is reimbursed, but at a rate that the provider considers to be insufficient due to the extensiveness and level of intensity of the services provided, the provider may submit an Adjustment Request Form for the paid (or allowed) E&M claim. Attach a copy of the emergency department visit report to the Adjustment Request Form and explain in the 'Other Comments' section of the form that a higher reimbursement is being requested.

When a specific surgical procedure (e.g., fracture care) is reimbursed, an E&M service is ordinarily not reimbursed for the same DOS. The reimbursement for the surgical procedure includes payment for E&M services as well. However, in unique circumstances, separate reimbursement for the E&M service may be available by submitting an Adjustment Request Form for the paid (or allowed) surgical claim. Attach a copy of the emergency department visit report to the Adjustment Request Form.

Evaluation and Management Services Provided with Surgical Procedures

If a provider performs an office or hospital visit and a surgical procedure on the same day for the same recipient, the provider will receive reimbursement only for the surgical procedure. However, if the surgery is a minor surgery (as determined by Wisconsin Medicaid), the provider may submit an Adjustment Request Form for the paid (or allowed) surgery claim to request additional reimbursement for the E&M service.

If the E&M service was unrelated to the surgery, the E&M service may be reimbursed if it is billed under a diagnosis code which is different than the diagnosis code for the surgery.

When a specific surgical procedure (e.g., fracture care) is reimbursed, an E&M service is ordinarily not reimbursed for the same DOS.

Family Planning Procedures

Family planning services are defined as services performed to enable individuals of childbearing age to determine the number and spacing of their children. This includes minors who may be considered sexually active. To enable the state to obtain Federal Financial Participation funding for family planning services, the accurate completion of three elements on the CMS 1500 claim form is essential. The three elements are:

1. Element 21 — Diagnosis.
2. Element 24E — Diagnosis Code Reference.
3. Element 24H — EPSDT (HealthCheck) and Family Planning Indicators.

Providers should refer to Appendix 4 of this handbook for detailed instructions on the

correct completion of these claim form elements.

Hospital Services

Wisconsin Medicaid ordinarily reimburses physicians for only a moderate level hospital admission procedure code if the physician has provided an E&M service or consultation at the highest level of service in the seven days prior to the hospital admission date.

Nursing Home Visits

Wisconsin Medicaid reimburses physicians for one routine nursing home visit per calendar month per recipient. If a physician visits a nursing home recipient more frequently, medical records must document the necessity of the additional visits.

When submitting a claim for a nursing home visit, use the most appropriate CPT procedure code based on the level of service provided.

Observation Care

Wisconsin Medicaid reimburses physicians providing observation care with procedure codes 99217-99220 or 99234-99236. Observation care includes all E&M services performed by the admitting physician on the date a recipient is admitted into observation care. This includes related services provided at other sites and all E&M services provided in conjunction with the admission into observation status.

Only the admitting physician may submit a claim for observation care. Other physicians must use another appropriate E&M outpatient or consultation procedure code.

When submitting claims for observation care, use the appropriate CPT procedure code. Reimbursement limitations for observation care include:

- Only one provider per DOS may be reimbursed for observation care for a recipient.
- Observation care is reimbursed only for place of service (POS) "2" (outpatient hospital/emergency room).
- Only one observation care procedure code per recipient per DOS may be reimbursed.
- Observation care codes are not reimbursed for patients admitted into hospital inpatient care on the same DOS.

Only the admitting physician may submit a claim for observation care. Other physicians must use another appropriate E&M outpatient or consultation procedure code.

Office and Other Outpatient Visits

Established Patient

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

New Patient

A new patient is defined as a patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the physician or group practice within the past three years.

Office Visit Daily Limit

Wisconsin Medicaid reimburses only one office visit per recipient, per provider, per DOS. However, an established patient visit may be payable in addition to a preventive medicine visit when the office visit is medically necessary and documented in the medical record.

Office Located in Hospital

Submit claims for services performed in a physician's office which is located in an outpatient hospital facility with a POS code "3" (office).

Office Visits and Counseling

Wisconsin Medicaid reimburses physicians for office visits during which the physician or the physician's designee counsels a recipient as to available courses of treatment. Submit a claim

for office counseling as an E&M service, even if counseling was the only service provided during the visit. This is true even if some of the possible courses of treatment discussed, and the one ultimately selected by the recipient, is not reimbursable under Wisconsin Medicaid.

Wisconsin Medicaid denies reimbursement for counseling services not identified as part of an E&M service (Physician's CPT counseling codes [99401-99404] are not recognized by Wisconsin Medicaid).

For example, Wisconsin Medicaid pays for an office visit to discuss options for treating cancer even though some of the options may include experimental treatments, which are not covered by Wisconsin Medicaid. Even if the recipient chooses an experimental treatment as a result of the office consultation, Wisconsin Medicaid would reimburse the physician for the E&M service.

Ancillary Providers

Coverage

Wisconsin Medicaid reimburses counseling and coordination of care services provided by ancillary providers (e.g., dieticians, genetics counselors, nutritionists) when those services are provided pursuant to a physician plan of care, are under the direct, on-site supervision of a physician, and are not included in the physician's E&M reimbursement.

Since ancillary providers are not Medicaid-eligible providers, claims for these services must be submitted under the supervising physician's Medicaid provider number.

"On-site" means that the supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Reimbursement

Reimbursement is limited to lower level established patient office/outpatient visits (procedure codes 99211 and 99212) for counseling and coordination services delivered by ancillary providers.

Wisconsin Medicaid does not separately reimburse ancillary provider counseling and care coordination services provided incidental to a physician office visit in which the physician has direct face-to-face contact with the recipient. In that case, face-to-face time refers to the time with the physician only.

Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time for purposes of reimbursement. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service for the physician office visit. The E&M procedure code used depends upon the physician service provided.

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Refer to the Surgery Services chapter of this section for more information about physician counseling visits related to abortions.

Preventive Medicine Services

Preventive medicine services are those office visits that relate to preventive medicine E&M of infants, children, adolescents, and adults. Reimbursement for preventive medicine services includes the following at the time of the preventive medicine evaluation:

- Counseling.
- Anticipatory guidance.
- Risk factor reduction.

"On-site" means that the supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention.

HealthCheck Program

Physicians may also provide preventive medicine services to recipients under age 21 as HealthCheck providers and receive enhanced reimbursement for their services. HealthCheck consists of a comprehensive health screening which includes all the following:

- A health and development history.
- An unclothed physical exam.
- An age-appropriate vision screen.
- An oral assessment plus direct referral to a dentist beginning at age three.
- Appropriate immunizations.
- Appropriate laboratory tests.

For more information about HealthCheck certification for physicians, refer to the General Information chapter of this section or to the HealthCheck Screening Services Handbook.

For more information about HealthCheck certification for physicians, refer to the General Information chapter of this section or to the HealthCheck Screening Services Handbook.

Medicine Services

A physician referring a recipient to a hearing instrument specialist or audiologist for a hearing aid must complete a Prior Authorization Request Form Physician Otological Report (PA/POR).

Wisconsin Medicaid covers most of the categories of medicine services described in *Current Procedural Terminology* (CPT). Refer to Appendix 1 of this section for medicine services that Wisconsin Medicaid covers. Providers should refer to other sources for the following services:

- Psychiatric services — Mental Health and Other Drug Abuse Services Handbook, and related *Wisconsin Medicaid and BadgerCare Updates*.
- Ophthalmology services — Vision Care Services Handbook and related *Updates*.

Allergy Tests

Claims for allergy tests must include the appropriate CPT procedure code(s) and the quantities of items provided or tests performed.

Audiometry

Basic comprehensive audiometry includes all of the following:

- Pure tone air audiometry.
- Pure tone bone audiometry.
- Speech audiometry, threshold.
- Speech audiometry, discrimination.

If the basic comprehensive audiometry test is billed in combination with any of the individual components of the comprehensive test for the same recipient on the same date of service (DOS), the individual component is denied and only the comprehensive audiometry test is reimbursed.

A physician referring a recipient to a hearing instrument specialist or audiologist for a hearing aid must complete a Prior Authorization Request Form Physician Otological Report (PA/POR). The physician should give the recipient page one of the PA/POR and keep page two for the recipient's medical records.

For a sample PA/POR and completion instructions, refer to Appendices 20 and 21 of this section.

Biofeedback

Wisconsin Medicaid reimburses physicians and physician assistants for biofeedback training, procedure codes 90901 and 90911. Only ***psychiatrists*** may be reimbursed for individual psychophysiological therapy incorporating biofeedback, procedure codes 90875 and 90876. Refer to the Mental Health and Other Drug Abuse Services Handbook and related *Updates* for limitations related to these procedure codes.

Chemotherapy

When chemotherapy for a malignant disease is provided in a physician's office, reimbursement is allowed for the following:

- Evaluation and management (E&M) visits.
- The drug and injection of the drug.
- Therapeutic infusions.
- Supplies.

Each of these services may be billed separately.

Refer to Appendix 1 of this section for procedure codes for E&M services. Use procedure code 99070 for supplies and materials provided by the physician.

Wisconsin Medicaid covers the chemotherapy drug procedure codes listed in the Physician Services Maximum Allowable Fee Schedule. Refer to Health Care Procedure Coding System (HCPCS), formerly HCFA Common

Procedure Coding System, codes for chemotherapy drug ("J") services. Reimbursement for these procedure codes includes the cost of the drug and the charge for injecting the drug. (If the physician's office does not supply the drug, use procedure code 90782 or 90784 to bill only for the injection. Use procedure codes 90780 and 90781 for prolonged infusions.)

When chemotherapy for a malignancy is provided in an inpatient hospital, outpatient hospital, or nursing home setting, only the E&M visit is reimbursable. Wisconsin Medicaid covers anti-emetic drugs for Medicaid recipients receiving chemotherapy. Providers should use the HCPCS "Q" codes when submitting claims for these services. Before submitting a claim, providers are responsible for verifying that a pharmacy is not already billing for an anti-emetic drug given to a recipient for the same DOS.

Clozapine Management

Clozapine management is a specialized care management service which may be required to ensure the safety of recipients who are using the psychoactive medication.

Wisconsin Medicaid reimburses clozapine separately for outpatient and nursing home residents. Clozapine ***management*** is reimbursable only for outpatients. Refer to Appendix 28 of this section for more information about Medicaid coverage of clozapine management.

Evoked Potentials

Only audiologists and physicians with specialties of neurology, otolaryngology, ophthalmology, physical medicine, rehabilitation, anesthesiology, and psychiatry can be reimbursed for evoked potential testing.

Wisconsin Medicaid covers the following evoked potential tests:

- Brain stem evoked response recording.
- Visual evoked potential study.
- Somatosensory testing.
- Intraoperative neurophysiological testing reimbursed by the hour.

These evoked potential tests are allowed once per day per recipient. When two or more types of evoked potential tests are performed on the same DOS (e.g., brain stem and visual), reimbursement is 100% of the allowed amount for the first test, with a lesser amount for the second and subsequent tests.

Hospital Admissions

An external review organization (ERO), under contract with the Department of Health and Family Services (DHFS), reviews the medical necessity of certain inpatient hospital admissions.

Complete medical record documentation is essential for the ERO at the time that the ERO requests the recipient's medical record from the hospital. Physicians must be certain that the recipient's record continually and adequately documents the recipient's condition and need for inpatient care.

Hospitals are responsible for notifying the ERO relative to the following admissions:

- All elective medical admissions (excluding maintenance chemotherapy). Wisconsin Medicaid defines an elective hospitalization as an admission that may be delayed without substantial risk to the patient.
- All elective admissions for surgical procedures identified on the ERO's outpatient procedure list.
- All substance abuse (alcohol and other drug abuse) admissions to general hospitals (all ages).
- All elective psychiatric admissions to general hospitals (all ages).
- All substance abuse admissions of individuals under age 21 to a specialty hospital (Institution for Mental Disease [IMD]).

When two or more types of evoked potential tests are performed on the same DOS (e.g., brain stem and visual), reimbursement is 100% of the allowed amount for the first test, with a lesser amount for the second and subsequent tests.

- All psychiatric admissions of individuals under age 21 to specialty hospitals (IMD).
- All elective admissions to IMD for recipients age 65 or over.

Certificate of Need Requirements for Recipients Admitted to an Institution for Mental Disease

Federal and state regulations require IMDs to conduct and document a Certificate of Need (CON) assessment for all recipients under the age of 21 who are admitted for elective/urgent or emergency psychiatric or substance abuse treatment services.

The CON form must be completed by a team of professionals, including at least one physician, working in cooperation with the hospital. The completed CON form must be readily available for ERO or DHFS review. For more information on CON requirements, refer to the Inpatient/Outpatient Hospital Services Handbook which can be found on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Wisconsin Medicaid's reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes ***includes*** reimbursement for the administration of the immunization, contrary to CPT's description of the procedure codes.

Immunizations

Wisconsin Medicaid covers the immunizations listed in the CPT subsections "Immune Globulins" (procedure codes 90281-90399) and "Vaccines, Toxoids" (procedure codes 90476-90749). Wisconsin Medicaid also covers certain immunizations that are billed using a local (or "W") code. Refer to Appendix 3 of this section for these local codes.

Wisconsin Medicaid's reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes ***includes*** reimbursement for the administration of the immunization, contrary to CPT's description of the procedure codes. CPT procedure codes for administration (procedure codes 90471 and 90472) are not covered by Wisconsin Medicaid.

Immune globulin procedure codes and the unlisted vaccine/toxoid procedure code are manually priced by Medicaid's pharmacy consultant. To be reimbursed for these codes, physicians must attach the following information to a paper CMS 1500 claim form:

- Name of drug.
- National Drug Code (NDC).
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Vaccines for Children Program

Wisconsin Medicaid provides certain vaccines to Medicaid-certified physicians under the Vaccines for Children (VFC) program. Refer to the Wisconsin Immunization Program Web site at *www.dhfs.state.wi.us/immunization/* to obtain more information about VFC. The Web site includes a vaccine order form and a list of vaccines that are provided free of charge for VFC-eligible children. Providers may also call the VFC program at (608) 267-5148 if Internet access is not available.

Children eligible for VFC include children who are uninsured or are Native American. Those children who are underinsured (e.g., have health insurance that does not cover immunizations) can be referred to their local health department or nearest federally qualified health center for vaccines.

The VFC vaccines are distributed through the DHFS Division of Public Health's Immunization Program.

Shipping

Vaccines provided through the VFC program are shipped to providers as the vaccine is ordered. The vaccines are sent directly to clinics for all physicians practicing in the clinic, or directly to physicians in independent practice. If affiliated with a Medicaid managed care program, a physician will receive periodic shipments of vaccines for all HMO and non-HMO-enrolled Wisconsin Medicaid recipients.

Physicians may use the VFC Vaccine Order Form (found on the Web site) to order their initial supply of vaccines or to order additional vaccines. If an emergency shipment is required or you do not have Internet access, call the Immunization Program directly at (608) 267-9959.

Shipments include free copies, on a dose-for-dose basis, of the federally required vaccine information statements for the following vaccines:

- Diphtheria, tetanus toxoids, and acellular pertussis (DTaP).
- Measles, mumps, and rubella (MMR).
- Pneumococcal conjugate.
- Polio.
- Tetanus and diphtheria toxoids (Td).
- Hemophilus influenza b (Hib).
- Hepatitis B.
- Varicella.

The annual amount of vaccine a physician receives from the VFC program must not exceed the amount physicians provide to Wisconsin Medicaid recipients, uninsured children, and Native American children. Consideration is made for an appropriate percentage of waste.

Billing and Reimbursement for Vaccines

Physicians may bill the appropriate procedure codes for all vaccines, including those provided through the VFC program. Wisconsin Medicaid *only* reimburses for the injection of each vaccine provided through the VFC program. Providers are not reimbursed for the cost of the vaccines since the Immunization Program sends the vaccines free to providers who give immunizations to Medicaid recipients.

If a patient encounter occurs in addition to the administration of the injection, physicians may bill the appropriate E&M procedure code which reflects the level of service provided at the time of the vaccination. If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be billed, in addition to the appropriate vaccine procedure code(s).

Vaccines that are commonly combined, such as MMR or DTaP, are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the recipient's medical record.

Injectable Drug Codes

Covered Procedure Codes

Wisconsin Medicaid covers the injectable drug procedure codes listed in the Physician Services Maximum Allowable Fee Schedule. Refer to HCPCS for injectable drug "J," "Q," and "S" procedure codes, and to Appendix 3 of this section for reimbursable local (or "W") codes. The Physician Services Maximum Allowable Fee Schedule is available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*. You may also purchase copies of the fee schedule from Wisconsin Medicaid. Copies are available on paper, tape cartridge, microfiche, or diskette. Refer to the Claims Submission section of the All-Provider Handbook for ordering instructions.

Prior Authorization Requirements

Refer to Appendix 12 of this section for injection procedure codes that require PA. Procedure code J3490 (unclassified drugs) requires PA only when the drug may also be used as a fertility drug. Use the Prior Authorization Request Form (PA/RF) and the Prior Authorization "J" Code Attachment (PA/JCA) to request PA.

Reimbursement

Wisconsin Medicaid's reimbursement for the HCPCS "J," "Q," and "S" codes, local "W" drug codes, and the unclassified drug code ***includes*** reimbursement for the administration of the drug. Therefore, providers should not bill an injection administration code (i.e., CPT procedure codes 90782-90788) concurrently with a drug code or concurrently with any

If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be billed, in addition to the appropriate vaccine procedure code(s).

other injection administration code except as noted below.

To be reimbursed for an unclassified drug that does not require PA or a covered "J," "Q," or "S" code that does not have a maximum allowable fee listed in the Physician Services Maximum Allowable Fee Schedule, physicians must submit a completed CMS 1500 claim form and attach the following information:

- Name of drug.
- National Drug Code.
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Providers may be separately reimbursed for an injection administration code only when the medication is supplied and independently billed by a pharmacy using an applicable NDC, or when the recipient possesses and provides the medication for injection by a provider.

Vitamin B-12

Vitamin B-12 injections are covered only for the following diagnoses:

- Alcohol neuropathies.
- Anemia, post-gastrectomy syndrome.
- Anemia, megaloblastic.
- Anemia, fish tapeworm.
- Anemia, pernicious.
- Anemia, post-bowel resection.
- Anemia, macrocytic.
- Cancer of the stomach, liver, intestines, and colon.
- Strictures of the small intestine.
- Anastomosis or partial resection of the small intestine.
- Posterolateral sclerosis.
- Sprue or other malabsorption states.
- Blind loop syndrome.
- Crohn's disease.

Corticosteroid Injections

Corticosteroid injections are limited to four injections per recipient per any rolling 365-day period, *unless* the recipient has one of the following diagnoses:

- Neoplasms.
- Endocrine, nutritional, and metabolic diseases and immune disorders.
- Diseases of blood and blood-forming organs.
- Multiple sclerosis.
- Other demyelinating diseases of the central nervous system.

Other Injections

Estrogen and estrone injections are limited to four per recipient per any 365-day period.

Laboratory Test Preparation and Handling Fees

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure. The physician who forwards the specimen is only reimbursed a handling fee.

If a physician obtains a specimen and forwards it to an outside laboratory, only the outside laboratory that performs the procedure may be reimbursed for the procedure.

Preparation and handling fees for forwarding a specimen from a physician's office to an outside laboratory is billed using procedure code 99000 (type of service [TOS] "5"). Procedure code 99001 (TOS "5") is used to bill for forwarding a specimen from someplace other than a physician's office to a laboratory. It is not necessary to indicate on the claim form the specific laboratory test performed.

A handling fee is not reimbursable if the physician is reimbursed for the professional and/or technical component of the laboratory test.

Additional Limitations

Additional limitations on reimbursement for handling fees are:

1. One lab handling fee is reimbursed to a physician per recipient, per outside laboratory, per DOS, regardless of the number of specimens sent to the laboratory.
2. More than one handling fee is reimbursed when specimens are sent to two or more laboratories for one recipient on the same DOS. Indicate the number of laboratories in the "Days or Units" field in Element 24G and the "$Charges" field in Element 24F of the CMS 1500 claim form. The name of the laboratory does not need to be indicated on the claim form; however, this information must be documented in your records.
3. A lab handling fee is reimbursed only when "yes" is indicated for outside laboratory in Element 20 of the CMS 1500 claim form.
4. The DOS must be the date the specimen is obtained from the recipient.

Screenings

Providers are required to use HCPCS procedure codes when submitting claims for the following screening procedures:

- Breast cancer — mammography.
- Colorectal cancer.
- Glaucoma.
- Pap smears.
- Pelvic and breast exams.
- Prostate cancer.

Refer to Appendix 1 of this section for a list of allowable HCPCS screening procedure codes.

General Principles

The following are general principles for Medicaid coverage of screening and diagnostic procedures:

- Wisconsin Medicaid covers both screening and diagnostic tests and procedures under the appropriate procedure codes.
- Office visits are included in the reimbursement for surgical procedures, whether diagnostic or screening (e.g., colonoscopy, flexible sigmoidoscopy). Providers should not submit claims for office visits when performing surgical procedures (HCPCS codes listed with TOS "2") on the same DOS.
- Laboratory and radiology screening and diagnostic procedures (HCPCS codes listed with TOS "4," "5," "Q," or "U") are separately reimbursable when submitted with an office visit procedure code on the same DOS.

Screening Procedures Coverage

Providers should use the screening procedure codes when submitting claims in the following instances:

- For routine tests or procedures performed to identify recipients at increased risk for diseases.
- When a recipient is asymptomatic or does not have a personal history of the disease (or related conditions) for which the screening test is being performed.

Wisconsin Medicaid does not limit the frequency, age criteria, or reasons for screening; rather, this is left to best medical judgement based on standard medical practice and the patient's individual circumstances.

Wisconsin Medicaid does not limit the frequency, age criteria, or reasons for screening; rather, this is left to best medical judgement based on standard medical practice and the patient's individual circumstances.

Claims for screenings must have the diagnosis code field completed (e.g., a preventive code). For example, a claim for a glaucoma screening could indicate *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnosis code V80.1 (Special

screening for neurological, eye, and ear diseases; Glaucoma).

Diagnostic Procedures

Providers should use diagnostic procedure codes when submitting claims in the following instances:

- There are symptoms or other indications of a medical problem or to confirm a previous diagnosis.
- There is a personal history of a medical problem or related condition.
- During a screening, a problem or medical condition is found and a biopsy or other sample is taken for further study and analysis.

Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films.

Service-Specific Information

The following information gives details about each kind of screening and/or when to bill services as diagnostic services. Refer to Appendix 1 of this section for screening procedure codes. Refer to CPT for diagnostic procedure codes.

Breast Cancer — Mammography

Wisconsin Medicaid does not have limitations on the frequency of mammography. Providers may be reimbursed for both a screening mammography and a diagnostic mammography for the same patient on the same DOS if they are performed as separate films. Reasons for the separate procedures must be documented in the recipient's medical record.

Wisconsin Medicaid does not recognize HCPCS modifiers "-GG" or "-GH" which are used by *Medicare* to indicate mammograms performed for the same patient on the same DOS.

Colorectal Cancer

Providers may submit claims for a variety of colorectal cancer screening or diagnostic tests, including laboratory tests, flexible sigmoidoscopy, proctosigmoidoscopy, barium enema, and colonoscopy. Providers should use the HCPCS or CPT procedure code that best reflects the nature of the procedure. If during a screening colonoscopy or sigmoidoscopy abnormalities (e.g., polyps) are found and biopsies taken or other coverage criteria are met (e.g., personal history of colon cancer), then the CPT diagnostic procedure code should be used.

Glaucoma

Wisconsin Medicaid covers glaucoma screening examinations when they are performed by or under the direct supervision of an ophthalmologist or optometrist. If a recipient has a previous history of glaucoma, use the CPT diagnostic procedure code when submitting a claim for services. In either case, Wisconsin Medicaid will not separately reimburse a provider for a glaucoma screening if an ophthalmological exam is provided to a recipient on the same DOS. Glaucoma screening and diagnostic examinations are included in the reimbursement for the ophthalmological exam.

Pap Smears

Wisconsin Medicaid reimburses both screening and diagnostic Pap smears. Wisconsin Medicaid will reimburse for both screening and diagnostic Pap smears for the same DOS if abnormalities are found during a screening procedure and a subsequent diagnostic procedure is done as follow-up. Providers are required to document this in the recipient's medical record.

Pelvic and Breast Exams

Wisconsin Medicaid will cover a screening pelvic and breast exam if it is the only procedure performed on that DOS. A pelvic and breast exam (HCPCS procedure code G0101) performed during a routine physical examination or a problem-oriented office visit is not separately reimbursable but is included in the reimbursement for the physical examination or office visit. When using an E&M office visit procedure code, the time and resources for the pelvic and breast exam

should be factored into the determination of the appropriate level for the office visit.

Prostate Cancer

Wisconsin Medicaid reimburses the following tests and procedures provided to an individual for the early detection and monitoring of prostate cancer and related conditions:

- Screening Digital Rectal Examination (DRE) — This test is a routine clinical examination of an asymptomatic individual's prostate for nodules or other abnormalities of the prostate.
- Screening Prostate Specific Antigen (PSA) Blood Test — This test detects the marker for adenocarcinoma of the prostate.
- Diagnostic PSA Blood Test — This test is used when there is a diagnosis or history of prostate cancer or other prostate conditions for which the test is a reliable indicator.

Reimbursement for a DRE is included in the payment for a covered E&M or preventive medical examination when the services are furnished to a recipient on the same day. If the DRE is the only service provided, the applicable procedure code may be reimbursed. The screening and diagnostic PSA tests are separately reimbursable when performed on the same DOS as an E&M or preventive medical exam.

Substance Abuse

Wisconsin Medicaid reimburses physicians for the following substance abuse services:

- Individual substance abuse therapy.
- Family substance abuse therapy.
- Group substance abuse therapy.

Psychotherapy services (except for biofeedback and pharmacological management) are reimbursable only for physicians with a psychiatric specialty.

Physicians interested in providing substance abuse or psychotherapy services should refer to publications for mental health/substance abuse clinics (nonboard owned and operated) which can be found on the Wisconsin Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* or call Provider Services at (800) 947-9627 or (608) 221-9883.

Telemedicine

Telemedicine is the use of telecommunications technology for diagnostic, monitoring, and medical education purposes. Wisconsin Medicaid does not cover telemedicine services.

Weight Alteration Services

Weight alteration services (e.g., diet clinics, obesity programs, weight loss programs) are reimbursable only if performed by or under the direct, on-site supervision of a physician and if performed in a physician's office. Weight alteration services exceeding five visits per calendar year require PA. Submit claims for weight alteration services with the appropriate E&M procedure code. Food supplements and dietary supplies (e.g., liquid or powdered diet foods or supplements, diet pills, and vitamins) are not separately reimbursable by Wisconsin Medicaid.

Psychotherapy services (except for biofeedback and pharmacological management) are reimbursable only for physicians with a psychiatric specialty. .

Surgery Services

Abortions

Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless whether the abortion itself was a covered service.

Coverage Policy

In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgement, that the abortion meets this condition by signing a certification.
2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the law enforcement authorities.
3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

Refer to Appendix 7 of this section for an optional Abortion Certification Statements form, which may be used for photocopying. Providers may develop a form of their own, provided it includes the same information.

Covered Services

When an abortion meets the state and federal requirements for Medicaid payment, Wisconsin Medicaid covers office visits and all other medically necessary related services. Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless whether the abortion itself was a covered service. Because the complications represent new conditions and thus the services are not directly related to the performance of an abortion.

Coverage of Mifeprex

Wisconsin Medicaid reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion procedures under s. 20.927, Wis. Stats. Under federal law, only physicians may obtain and dispense Mifeprex.

When submitting claims for Mifeprex, providers are required to:

- Use the Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, code S0190 (Mifepristone, oral, 200 mg), type of service (TOS) "1," for the first dose of Mifeprex, along with the evaluation and management (E&M) code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- Use the HCPCS code S0191 (Misoprostol, oral, 200 mcg), TOS "1," for the drug given during the second visit, along with the E&M code that reflects the service provided. Do not use HCPCS code S0199; bill components (i.e., ultrasounds, office visits) of services performed separately.
- For the third visit, use the E&M code that reflects the service provided.
- Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* abortion diagnosis code with each claim submission.
- Attach to each claim a completed abortion certification statement that includes information showing the situation is one in

which Wisconsin Medicaid covers the abortion. Refer to Appendix 7 of this section for the Abortion Certification Statements form.

Note: Wisconsin Medicaid denies claims for Mifeprex reimbursement when billed with a National Drug Code.

Physician Counseling Visits Under s. 253.10, Wis. Stats.

Section 253.10, Wis. Stats., provides that a woman's consent to an abortion is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute. That information includes, among other things, all of the following:

- Whether the woman is pregnant.
- Medical risks associated with the woman's pregnancy.
- Details of the abortion method that would be used.
- Medical risks associated with the particular abortion procedure.
- "Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion."

Wisconsin Medicaid will cover an office visit during which a physician provides the information required under s. 253.10, Wis. Stats., even if the woman decides to undergo an abortion and even if the abortion performed is not Medicaid covered.

Pursuant to s. 253.10, Wis. Stats., the Department of Health and Family Services has issued preprinted material summarizing the statutory requirements under s. 253.10, Wis. Stats.

Services Incidental to a Noncovered Abortion

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Laboratory testing and interpretation.
- Recovery room services.
- Transportation.
- Routine follow-up visits.
- Ultrasound services.

Services Provided by Provider of a Noncovered Abortion

A Medicaid provider performs a noncovered abortion on a Medicaid recipient. The provider claims reimbursement for other services that were provided to the same recipient between nine months prior to and six weeks after the noncovered abortion. Wisconsin Medicaid requires the provider in this situation to comply with the following requirements:

- All claims must be submitted on paper, not electronically.
- Each claim must have the following signed written statement:

  No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s. 49.49, Wis. Stats., and HFS 106.06(17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both.

  Provider's Name
  Provider's Medicaid Number
  Provider's Signature and Date

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid.

Anesthesia by Surgeon

Reimbursement for anesthesia provided by the surgeon (e.g., local infiltration, digital block, topical anesthesia, regional, and general anesthesia) is included in the Medicaid reimbursement for the surgical or diagnostic procedure(s) performed and is not separately reimbursable.

However, if the anesthesia is the primary procedure performed, for diagnosis or treatment, it is separately reimbursable. For example, if an intercostal nerve block is done for diagnosis and treatment of post-therapeutic neuralgia, and an epidural steroid injection procedure is also done, the anesthetic procedure is separately reimbursable.

Refer to the Anesthesia section of this handbook for more information.

Contraceptive Implants

Wisconsin Medicaid covers contraceptive implant devices (e.g., Norplant). Reimbursement for the contraceptive implant procedure includes the E&M service, supplies, and the cost of the device. Providers should not submit claims for E&M services and supplies associated with contraceptive implant services, unless another separate and distinct service is provided and documented in the recipient's medical record.

Wisconsin Medicaid recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to recipients prior to the implantation procedure.

Indicate *Current Procedural Terminology* (CPT) code 11975, 11976, or 11977, TOS "2" (surgery), on the claim.

Informed Consent Procedure

Wisconsin Medicaid recommends that providers of implantable contraceptives have a fully informed consent procedure and present comprehensive information to recipients prior to the implantation procedure. This information should include the following:

- Physiological effects of contraceptive implants.
- Risks associated with implant use.
- Potential side effects.
- Recommendations for follow-up care and removal.

As part of the informed consent process, the Division of Health Care Financing (DHCF) recommends using information provided in the patient education materials supplied by the manufacturer. Recipients should be informed of the following considerations:

- Some patients may experience thick, permanent scarring of the skin at the insertion and removal site (keloid formation).
- Migration of the capsules may occur making removal difficult.
- Women can request the implant be removed at any time.
- The implant does not provide protection against sexually transmitted diseases.

Wisconsin Medicaid recommends providing a waiting period between the education session and the insertion of the implant, as it may help ensure that a proper amount of time is allowed for an informed decision. Some providers indicate that this allows increased recipient acceptance of the implant. Such a waiting period may not always be acceptable, however, considering factors such as recipient preferences and limited transportation.

Informed Consent Documentation

Informed consent should be documented in the recipient's medical record and must include the signatures or initials of both the provider and the recipient.

Co-surgeons/Assistant Surgeons

Under certain circumstances, the expertise of two or more surgeons (usually, but not always, with different specialties) may be required in the management of specific surgical procedures. In these cases, both surgeons submit claims for the surgery code(s) with a TOS "2." Each surgeon is reimbursed at Wisconsin Medicaid's usual surgeon rate for

the specific procedure he or she has performed. Attach documentation (such as an operative report) to each surgeon's claim form to demonstrate medical necessity and to identify the co-surgeons.

When two or more surgeons perform one or more procedures which are generally performed by a surgeon and an assistant (or assistants), the principal surgeon bills the surgery code(s) with TOS "2" and the additional surgeon(s) bills the surgery code(s) with TOS "8."

Dilation and Curettage

Dilation and curettage (D&C), diagnostic or therapeutic (nonobstetrical), requires a second opinion when performed on an elective basis. Refer to Appendix 25 of this section for the emergent/urgent criteria when D&C does not require a second opinion. In cases when a second opinion is not required, attach documentation such as the preoperative history and physical exam report.

Foot Care

Wisconsin Medicaid reimburses physicians for the cleaning, trimming, and cutting of toenails once per 31 days (for one or both feet) if the recipient has one of the following systemic conditions:

- Diabetes mellitus.
- Arteriosclerosis obliterans evidenced by claudication.
- Cerebral palsy.
- Peripheral neuropathies involving the feet, which are associated with one of the following:
  - ✓ Malnutrition or vitamin deficiency.
  - ✓ Carcinoma.
  - ✓ Diabetes mellitus.
  - ✓ Drugs and toxins.
  - ✓ Multiple sclerosis.
  - ✓ Uremia.

Unna Boots

The application of unna boots is reimbursable for recipients with one of the following diagnoses:

- Varicose veins of lower extremities.
- Venous insufficiency, unspecified.
- Chronic ulcer of skin.
- Decubitus ulcer of lower extremity.
- Ulcer of lower limbs.
- Edema of lower extremities.

Reimbursement for the cost of the unna boot is included in the reimbursement for the application procedure.

Gastric Surgery for Obesity

Gastric bypass and gastric stapling are only covered in limited circumstances and require prior authorization (PA). Physicians must submit documentation supporting the medical necessity for the procedure, including a current history/physical exam report and laboratory reports with the Prior Authorization Physician Attachment (PA/PA). The review of the documentation and determination of medical necessity is made by the Wisconsin Medicaid physician consultant.

Hysterectomies

Wisconsin Medicaid does not cover a hysterectomy for uncomplicated fibroids, fallen uterus, or retroverted uterus.

Wisconsin Medicaid does not cover a hysterectomy for uncomplicated fibroids, fallen uterus, or retroverted uterus.

Reimbursement for a hysterectomy requires both a second surgical opinion and the completion of the Acknowledgment of Receipt of Hysterectomy Information form, except as noted below.

Second Opinion Elective Surgery Request/Physician Report Form

Except in urgent, emergent, or certain special circumstances, a second surgical opinion must be obtained prior to performing the

hysterectomy. For more information about the second opinion requirement, including exceptions to the requirement, procedures for obtaining the second opinion, instructions for completing the second opinion form, and options for submitting the form, refer to "Second Surgical Opinion" later in this chapter and to Appendices 23-26 of this section.

Acknowledgment of Receipt of Hysterectomy Information Form

Except in the situations noted below, an Acknowledgment of Receipt of Hysterectomy Information form must be completed prior to the surgery and attached to the CMS 1500 claim form. Providers may develop their own form as long as it includes all the same information as Wisconsin Medicaid's form. Refer to Appendix 10 of this section for a copy of the form. The form is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of the Acknowledgment of Receipt of Hysterectomy Information form or similar form with the same information.

A hysterectomy may be covered ***without*** a valid acknowledgment form if one of the following circumstances applies:

- The recipient was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the recipient's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation, in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive recipient eligibility and one of the following circumstances applied:
  - ✓ The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  - ✓ The recipient was already sterile.
  - ✓ The recipient was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions above, the physician must identify the applicable circumstance in writing in signed and dated documentation attached to the CMS 1500 claim form. (A copy of the preoperative history/physical exam and operative report is usually sufficient.)

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of the Acknowledgment of Receipt of Hysterectomy Information form or similar form with the same information. The form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent Form.

Intrauterine Devices

Wisconsin Medicaid reimburses physicians separately for the intrauterine device (IUD) and IUD insertion and removal procedures. However, reimbursement for the E&M office visit and for necessary supplies are included in the reimbursement for the IUD insertion and removal procedures. Do not bill for the E&M visit or the supplies unless another separate and distinct service is provided and documented in the recipient's medical record.

Intrauterine Device Procedure Codes

Procedure Code	Description
J7300 (TOS 1)	Intrauterine copper contraceptive
J7302 (TOS 1)	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
W6200 (TOS 1)	Intrauterine device — progesterone
58300 (TOS 2)	Insertion of intrauterine device (IUD)
58301 (TOS 2)	Removal of intrauterine device (IUD)

Obstetric Services

Wisconsin Medicaid offers providers choices of how and when to file claims for obstetric (OB) care. Providers may choose to submit claims using either the separate OB component procedure codes as they are performed or the appropriate global OB procedure code with the date of delivery as the date of service (DOS).

Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery. The exception to this rule is in the case of multiple births, where more than one delivery may be reimbursed (see "Delivery" section of this chapter for details).

Separate Obstetric Care Components

Providers should use the following guidelines when submitting claims for separate OB components.

Antepartum Care

Antepartum care includes dipstick urinalysis, routine exams and recording of weight, blood pressure, and fetal heart tones.

Providers should refer to the table on this page as a guide for submitting claims for a specific number of antepartum care visits. Providers should provide all antepartum care visits before submitting a claim to Wisconsin Medicaid.

Providers should use local procedure codes W6000 — "antepartum care; initial visit" — and W6001 — "antepartum care; two or three visits" — when submitting claims for the first through third antepartum care visits with a provider or provider group. For example, if a total of two or three antepartum care visits is performed, the provider should indicate procedure code W6000 and a quantity of "1.0" for the first DOS. For the second or third visits, the provider should indicate procedure code W6001 and a quantity of "1.0" or "2.0," as indicated in the table. The date of the last antepartum care visit is the DOS.

Note: Do not use evaluation and management procedure codes when submitting claims for the first three antepartum care visits. Use of these codes may result in improper reimbursement.

Similarly, for CPT codes 59425 — "antepartum care only; 4-6 visits" — and 59426 — "antepartum care only; 7 or more visits" — the provider should indicate the date of the last antepartum care visit as the DOS. The quantity indicated for these two codes may not exceed "1.0."

Occasionally, a provider may be unsure of whether a recipient has had previous antepartum care visits with another provider. If the recipient is unable to provide this information, the provider should assume the first time he or she sees the recipient is the first antepartum visit.

Note: Reimbursement for procedure codes W6000, W6001, 59425, and 59426 is limited to once per pregnancy, per

W Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care codes if a provider also submits a claim for global OB care codes for the same recipient during the same pregnancy or delivery.

Antepartum Care Claims Submission Guide

Total Visit(s)	Procedure Code*	Description	Quantity
1	W6000	Antepartum care; initial visit	1.0
2	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	1.0
3	W6000	Antepartum care; initial visit	1.0
	W6001	Antepartum care; two or three visits	2.0
4-6	59425	Antepartum care only; 4-6 visits	1.0
7+	59426	7 or more visits	1.0

*Claims for these codes should be submitted with the following TOS:

- Physicians, physician assistants, and nurse practitioners use TOS "2."
- Assistant surgeons during delivery use TOS "8."
- Nurse midwives use TOS "9."

recipient, per billing provider. A telephone call between patients and providers does not qualify as an antepartum visit.

Delivery

Delivery includes patient preparation, placement of fetal heart or uterine monitors, insertion of catheters, delivery of the child and placenta, injections of local anesthesia, induction of labor, and artificial rupture of membranes.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following vaginal or cesarean delivery.

Providers who perform vaginal or cesarean deliveries may submit claims using the appropriate delivery codes. A clinic or group may submit claims for the delivery component separately and should indicate the provider who performed the delivery as the performing provider, rather than the primary OB provider.

When there are multiple deliveries (e.g., twins, triplets), providers should submit one claim for all of the deliveries. On the first detail line of the CMS 1500 claim form, indicate the appropriate procedure code for the first delivery. Indicate additional births on separate detail lines of the claim form, using the appropriate delivery procedure code for each delivery.

Wisconsin Medicaid does not recognize modifiers "-51" or "-22."

Induction or Inhibition of Labor

Pitocin drip and tocolytic infusions are not separately reimbursable when provided on the date of delivery. Induction or inhibition of labor are only reimbursable when physician services are documented in the medical record and when performed on dates other than the delivery date. The service is indicated using CPT code 59899 — "Unlisted procedure, maternity care and delivery" — with supporting documentation attached to the claim.

Postpartum Care

Postpartum care includes all routine management and care of the postpartum patient including exploration of the uterus, episiotomy and repair, repair of obstetrical lacerations and placement of hemostatic packs or agents. These are part of both the post-delivery and post-hospital office visits, both of which must occur in order to receive reimbursement for postpartum care or global obstetric care.

Wisconsin Medicaid reimbursement for postpartum care includes hospital *and* office visits following vaginal or cesarean delivery. In accordance with the standards of the American College of Obstetricians and Gynecologists, postpartum care includes *both* the routine post-delivery hospital care *and* an outpatient/office visit. Post-delivery hospital care alone is included in the reimbursement for delivery. When submitting claims for postpartum care, the DOS is the date of the post-hospital discharge office visit. In order to receive reimbursement, the recipient *must* be seen in the office. The length of time between a delivery and the office postpartum visit should be dictated by good medical practice. Wisconsin Medicaid does not dictate an "appropriate" period for postpartum care; however, the industry standard is six to eight weeks following delivery. A telephone call between patients and providers does *not* qualify as a postpartum visit.

Delivery and Postpartum Care

Providers who perform both the delivery and postpartum care may use either the separate delivery and postpartum codes or the delivery including postpartum care CPT procedure codes 59410, 59515, 59614, or 59622, as appropriate. The DOS for the combination codes is the delivery date. However, if the recipient fails to return for the postpartum visit, the provider must adjust the claim to reflect delivery only or the reimbursement will be recouped through audit.

Global Obstetric Care

Providers may submit claims using global OB codes. Providers choosing to submit claims for global OB care must perform all of the following:

- A minimum of six antepartum visits.
- Vaginal or cesarean delivery.
- The post-delivery hospital visit and a minimum of one postpartum office visit.

When submitting claims for total OB care, providers should use the single most appropriate CPT OB procedure code and a single charge for the service. Use the date of delivery as the DOS.

All services must be performed to receive reimbursement for global obstetric care. Providers are required to provide all six (or more) antepartum visits, delivery, and the postpartum office visit in order to receive reimbursement for global OB care. If fewer than six antepartum visits have been performed, the provider performing the delivery may submit a claim using the appropriate delivery procedure code and, as appropriate, antepartum and postpartum visit procedure codes.

If the required postpartum office visit does not occur following claims submission for the global delivery, the provider must adjust the claim to reflect antepartum care and delivery if there is no documentation of a postpartum visit in the patient's medical record. (Refer to the section on postpartum care.)

Group Claims Submission for Global Obstetric Care

When several OB providers in the same clinic or medical/surgical group practice perform the delivery and provide antepartum and postpartum care to the same recipient during the period of pregnancy, the clinic may choose to submit a claim using a single procedure code for the service. When submitting the claims, providers should indicate the group Medicaid billing number and identify the primary OB provider as the performing provider.

Separately Covered Pregnancy-Related Services

Services that may be reimbursed separately from the global or component obstetrical services include:

- Administration of RH immune globulin.
- Amniocentesis, chorionic villous sampling, and cordocentesis.
- Epidural anesthesia. (Refer to the Anesthesia section of this handbook for epidural anesthesia claims submission information.)
- External cephalic version.
- Fetal biophysical profiles.
- Fetal blood scalp sampling.
- Fetal contraction stress and non-stress tests.
- Harvesting and storage of cord blood.
- Insertion of cervical dilator.
- Laboratory tests, excluding dipstick urinalysis.
- Obstetrical ultrasound and fetal echocardiography.
- Sterilization. (Refer to the "Sterilizations" section of this chapter for sterilization limitations.)
- Surgical complications of pregnancy (e.g., incompetent cervix, hernia repair, ovarian cyst, Bartholin cyst, ruptured uterus, or appendicitis).

Unusual Pregnancies

Providers treating recipients whose pregnancies require more than the typical number of antepartum visits or result in complications during delivery may seek additional reimbursement by submitting an Adjustment Request Form. The provider should include a copy of the medical record and/or delivery report specifying the medical reasons for the extraordinary number of antepartum or postpartum visits. A medical consultant will review the materials and

All services must be performed to receive reimbursement for global obstetric care.

determine the appropriate level of reimbursement.

Wisconsin Medicaid does not recognize the "-22" modifier.

Complications of Pregnancy

Complications of pregnancy or delivery, such as excessive bleeding, pregnancy-induced hypertension, toxemia, hyperemesis, or premature (not-artificial) rupture of membranes, and other complications during the postpartum period may all be reported and reimbursed separately from obstetrical care. The nature of these complications should be fully documented in the patient's medical record.

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider group, whether the reimbursement is made through fee-for-service or through a Medicaid managed care program.

Unrelated Conditions

Any E&M services performed that are related to the pregnancy are included in reimbursement for obstetrical care. However, conditions unrelated to the pregnancy may be separately reimbursed by Wisconsin Medicaid. These include:

- Chronic hypertension.
- Diabetes.
- Management of cardiac, neurological, or pulmonary problems.
- Other conditions (e.g., urinary tract infections) with a diagnosis other than complication of pregnancy.

Health Personnel Shortage Area Incentive Reimbursement

All OB procedure codes are eligible for the Health Personnel Shortage Area (HPSA) incentive reimbursement. Submit claims indicating the appropriate HPSA modifier "HP" or "HK" to receive a 50% bonus incentive. Refer to the Billing and Reimbursement chapter of this section for further information.

Other Insurance/Private Pay Prior to Wisconsin Medicaid Eligibility

Wisconsin Medicaid OB payments apply only to services provided while the person is eligible as a Medicaid recipient. Services provided prior to Wisconsin Medicaid eligibility are not included in the number of antepartum visits, the delivery, or postpartum care.

Fee-for-Service Recipients Subsequently Enrolled in a Medicaid Managed Care Program

Wisconsin Medicaid will reimburse the equivalent of one global OB fee per recipient, per delivery, per single provider or provider group, whether the reimbursement is made through fee-for-service or through a Medicaid managed care program.

When a recipient who is initially eligible for fee-for-service Medicaid enrolls in a Medicaid managed care program during her pregnancy and receives care from the same provider or clinic when eligible for Medicaid fee-for-service and when enrolled in a Medicaid managed care program, her provider may be paid a global fee by the managed care program after fee-for-service has paid for antepartum care. The provider is then required to submit an adjustment(s) to have the fee-for-service Medicaid payment recouped.

If the provider does not submit the adjustment(s) in this situation, Wisconsin Medicaid will recoup the fee-for-service payment(s) through audit. If the recipient receives less than total OB care while enrolled in the Medicaid managed care program, Wisconsin Medicaid reimburses her provider no more than the global maximum allowable fee or the sum of the individual components for services. Wisconsin Medicaid will, on audit, recoup any amount paid under fee-for-service that is above the global fee or the combined maximum allowable fee for the services if billed separately.

Newborn Reporting

Providers are required to promptly report newborns born to fee-for-service Medicaid recipients to Wisconsin Medicaid. Establishing a newborn's Medicaid eligibility results in better health outcomes and fewer delays in provider reimbursement. Refer to Appendix 33 of this section for a sample Wisconsin Medicaid Newborn Report form. Providers may also obtain the Newborn Report from the forms section of the Medicaid Web site at *www.dhfs.state.wi.us/medicaid.*

Providers Required to Report Newborns

Hospitals, Medicaid HMOs, physicians, nurse practitioners, and nurse midwives may report newborns born to Medicaid recipients by submitting a Wisconsin Medicaid Newborn Report, or another form developed by the provider that contains all the same information, to Wisconsin Medicaid.

Physicians, nurse practitioners, and nurse midwives should *only* complete a Newborn Report if the recipient is not enrolled in an HMO and the birth occurs outside a hospital setting. Otherwise, the Medicaid HMO or hospital should complete the form.

Newborn Report Submission

Providers have the option of sending newborn reports in a summary format on a weekly basis to Wisconsin Medicaid or individual reports for each newborn. However, the summary report must contain all the information provided in the Newborn Report.

If possible, the Newborn Report form should be submitted to Wisconsin Medicaid with the child's given name (first and last name), rather than "baby boy" or "baby girl" as the first name. The four-digit year should be included when reporting the child's date of birth. (To report a child's date of death, the two- or four-digit year format may be used). Wisconsin Medicaid still requires providers to submit a Newborn Report in instances in which the baby is born alive, but does not survive.

Submit the Newborn Report form to Wisconsin Medicaid by mail or fax:

Wisconsin Medicaid
PO Box 6470
Madison WI 53716
Fax: (608) 224-6318

This information on newborn reporting pertains to the birth of a newborn to a Medicaid recipient who is not enrolled in an HMO.

Recipients Enrolled in Medicaid HMOs

Under the Medicaid managed care contract, HMOs are required to report to Wisconsin Medicaid the birth of a newborn to a mother enrolled in an HMO. Because of this requirement, hospitals and HMOs should coordinate the newborn reporting function to prevent duplicate reporting by the hospital and HMO of the same newborn. Following these procedures assures more timely reimbursement for services provided to infants.

Newborn Report Procedures

Once the completed Newborn Report is submitted to Wisconsin Medicaid, the following procedures take place:

- A pseudo (temporary) Medicaid identification number is assigned to the newborn, regardless of whether the newborn is named (if Medicaid eligibility is not yet on file).
- A Medicaid Forward card is created for the child and sent to the mother as soon as the child's eligibility is put on file.
- Wisconsin Medicaid sends a letter to the mother, notifying her of the child's eligibility. The letter also contains a statement that the mother is required to sign, stating that the baby has continued to live with her since birth. She must send this statement to her county or tribal eligibility worker in the envelope provided and is required to tell her eligibility worker that she has a new baby with a temporary Medicaid identification number.
- A copy of this letter is also sent to the county economic support agency.

P Physicians and nurse midwives should only complete a Newborn Report if the recipient is not enrolled in an HMO and/or the birth occurs outside a hospital setting.

- Once the mother notifies her worker and her child has received a Social Security number, a permanent Medicaid number is assigned to the child.
- The provider receives a copy of the eligibility notification letter sent to the child's mother as confirmation.

Providers with questions regarding newborn eligibility may contact Provider Services at (800) 947-9627 or (608) 221-9883.

R Refer to Appendix 30 of this section for the list of Medicaid-approved organ transplant institutions.

Newborn Screenings

Wisconsin Medicaid covers the cost of prepaid filter paper cards in addition to the laboratory handling fee for newborn screenings provided outside a hospital setting. Refer to the Laboratory and Radiology section of this handbook for more information.

Organ Transplants

Wisconsin Medicaid reimburses physicians for bone marrow, heart, heart/lung, lung, liver, intestine, liver/small intestine, pancreas, and pancreas/kidney transplants when:

- Appropriate and medically necessary.
- Prior authorized.
- Performed in an approved institution.

Prior to making a referral to an approved institution, Wisconsin Medicaid recommends that physicians contact the facility to determine if the facility currently accepts Wisconsin Medicaid recipient referrals and Medicaid reimbursement for the proposed transplant. Refer to Appendix 30 of this section for the list of Medicaid-approved organ transplant institutions.

Kidney and cornea transplants do not require PA or an approved institution as the place of service.

Prior Authorization Requirements

For all transplants requiring PA, the transplant program of the hospital in which the transplant will occur must request PA, *not* the physician. However, physicians involved with the transplant should verify that the hospital has received PA. If PA is not obtained, neither the hospital, the surgeon(s), nor any other physicians involved are reimbursed for the transplant services.

Hospitals must obtain PA for *all* transplant patients including those in a Medicaid managed care program.

Physicians should *not* indicate the PA number on a claim for a transplant surgery.

In cases of multiple organ transplants where no single CPT code describes the procedure performed, indicate each individual procedure code, if available, on the Prior Authorization Request Form (PA/RF). For liver/small intestine transplants, use procedure code 47399 (unlisted procedure, liver).

Second Surgical Opinion

Wisconsin Medicaid requires a second opinion for selected elective surgical procedures. This allows a recipient the opportunity to make an informed decision about undergoing surgery. The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

Procedures requiring a second opinion may be performed without a second opinion in urgent or emergent circumstances. In such cases, documentation (such as a preoperative history and physical exam report) must be submitted with the claim. Appendix 24 of this section lists the CPT codes of the procedures requiring a second surgical opinion. Appendix 25 of this section lists the urgent or emergency indications which, if documented, permit a waiver of the second surgical opinion.

Second opinions may be performed by any Wisconsin Medicaid-certified physician, but

not by nurse practitioners or physician assistants. Refer to the following appendices of this section for additional information about second surgical opinions:

- Appendix 23, Second Surgical Opinion Requirement.
- Appendix 24, Surgery Procedure Codes That Require a Second Opinion.
- Appendix 25, Second Surgical Opinion Waivers.
- Appendix 26, Second Opinion Elective Surgery Request/Physician Report form.

Sterilizations

General Requirements

A sterilization is any surgical procedure performed with the ***primary*** purpose of rendering an individual permanently incapable of reproducing. The procedure may be performed in an "open" or laparoscopic manner. This does not include procedures that, while they may result in sterility, have a different purpose such as surgical removal of a cancerous uterus or cancerous testicles.

Medicaid reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements and satisfactory completion of a Sterilization Informed Consent form. There are no exceptions. Federal and state regulations require the following:

- The recipient is not an institutionalized individual.
- The recipient is at least 21 years old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not a mentally incompetent individual. Wisconsin Medicaid defines a "mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:

  ✓ In the case of premature delivery, the sterilization is performed at the time of premature delivery ***and*** written informed consent was given at least 30 days before the expected date of delivery ***and*** at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.

  ✓ The sterilization is performed during emergency abdominal surgery ***and*** at least 72 hours have passed since the recipient gave written informed consent for sterilization.

Sterilization Consent Form

A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form. Sterilization coverage requires accurate and thorough completion of the consent form. The physician is responsible for obtaining consent. Refer to Appendices 8 and 9 of this section for a copy of the required Sterilization Informed Consent form and the completion instructions with a sample copy. Any corrections to the form must be signed and dated by the physician and/or recipient, as appropriate.

A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form.

Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.

To ensure payment for sterilizations, providers are urged to use the Medicaid Sterilization Informed Consent form before all

sterilizations in the event that the patient obtains Medicaid retroactive eligibility.

Physicians must attach the completed consent form to the CMS 1500 claim form to obtain reimbursement. Since an attachment is necessary, this claim cannot be submitted electronically.

Consent forms may also be obtained at *www.dhfs.state.wi.us/medicaid/* or by writing to:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

To be eligible for Wisconsin Medicaid-reimbursed TMJ surgery, a recipient must have received appropriate nonsurgical treatment which has not resolved or improved the recipient's condition.

Temporomandibular Joint Surgery

Wisconsin Medicaid reimburses an E&M office visit for the purpose of assessing temporomandibular joint (TMJ) dysfunction. A TMJ office visit generally consists of the following for a recipient experiencing TMJ dysfunction:

- Comprehensive history.
- Detailed and extensive clinical examination.
- Diagnosis.
- Treatment planning.

Refer to Appendix 29 of this section for a list of TMJ procedure codes and TMJ evaluation programs.

To be eligible for Wisconsin Medicaid-reimbursed TMJ surgery, a recipient must have received appropriate nonsurgical treatment which has not resolved or improved the recipient's condition. Nonsurgical treatment generally includes the following:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

Prior Authorization Requirements

Wisconsin Medicaid requires PA for TMJ surgery. Before submitting a PA request for TMJ surgery, the recipient must be evaluated by a multi-disciplinary TMJ evaluation program or clinic approved by the DHCF. Refer to Appendix 29 of this section for a list of approved TMJ programs. The evaluation must be done by a facility not previously involved in the treatment of the recipient. The multi-disciplinary evaluation includes:

- A dental evaluation conducted by an oral/maxillofacial surgeon, orthodontist, or general practice dentist.
- A physical evaluation conducted by a physician knowledgeable of TMJ problems and therapies.
- A psychological evaluation conducted by a psychiatrist or psychologist.

The surgeon who will perform the TMJ surgery requests PA using the PA/RF and the PA/PA. Information submitted must include:

- Documentation describing all prior nonsurgical treatments, treatment dates, and treatment outcomes.
- A copy of the multi-disciplinary evaluation.
- The type of surgical procedure being considered.

A PA request received without an attached multi-disciplinary evaluation will be returned so that an evaluation can be documented. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

If a recipient is enrolled in a Medicaid HMO, a multi-disciplinary evaluation and PA by Wisconsin Medicaid are not required. The HMO may require a multi-disciplinary

evaluation and will be responsible for payment of all medical costs related to the evaluation.

In addition, the HMO (not Medicaid fee-for-service) is responsible for paying the cost of all related medical and hospital services. The HMO may; therefore, designate the facility at which the surgery will be performed.

Physicians must participate in or obtain a referral from the recipient's HMO, since the HMO is responsible for paying the cost of all services. Failure to obtain an HMO referral may result in a denial of payment for services by the HMO.

Prescription Requirements

Prescriptions for Drugs

Wisconsin Medicaid reimburses a pharmacy for a brand-name drug at the same rate allowed for the generic equivalent ***unless*** the prescriber certifies that the brand-name drug is medically necessary and documents the medical necessity in the recipient's medical record.

Wisconsin Medicaid covers both legend and certain over-the-counter (OTC) drugs. (A legend drug is one whose outside package has the legend or phrase "Caution, Federal law prohibits dispensing without a prescription" printed on it.)

Medicaid coverage for some drugs is restricted by diagnosis code or prior authorization. Drugs that are identified by the Food and Drug Administration as less-than-effective (LTE) or as identical, related, or similar to LTE drugs are not covered by Wisconsin Medicaid. Drugs identified on the Wisconsin Negative Formulary are also not covered.

For more information regarding Medicaid's coverage, providers may reference the Pharmacy Handbook on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

General Prescription Requirements

It is vital that physicians, physician assistants, and nurse practitioners provide adequate documentation for a pharmacy or other providers to fill a prescription for a legend or OTC drug. Except as otherwise provided in federal or state law, a prescription must be in writing, or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed.
- The date of issue of the prescription.
- The prescriber's name and address.
- The recipient's name and address.
- The prescriber's signature (if the prescriber writes the prescription) and date signed.
- The directions for use of the prescribed drug or item.

For hospital and nursing home recipients, prescriptions must be entered into the medical and nursing charts, and must include the above information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills which are valid for shorter periods of time.

Special Considerations When Prescribing Drugs

Prescribing Brand-Name Legend Drugs

Wisconsin Medicaid reimburses a pharmacy for a brand-name drug when generics are available at the same rate allowed for the generic equivalent ***unless*** the prescriber certifies that the brand-name drug is medically necessary and documents the medical necessity in the recipient's medical record. This requirement applies only to legend drugs.

Prescribers must write the phrase "BRAND MEDICALLY NECESSARY" on the prescription. (Phrases like "NO SUBSTITUTES" or "N.S." are not acceptable.) This certification must be in the prescriber's own handwriting directly on the prescription order or on a separate order which is attached to the original prescription. Typed certification, signature stamps, or certification handwritten by someone other than the prescribing physician does not satisfy this requirement.

A letter of certification is acceptable as long as the notation is handwritten, is for specified drugs for an individual recipient, and is valid for not more than one year. A "blanket" authorization for an individual recipient, drug, or prescriber is not acceptable.

For recipients in nursing homes, prescriber certification that the brand is medically

necessary must be made on each prescription order written. This certification is valid only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

While it is the responsibility of pharmacies to have this documentation before submitting their claims to Wisconsin Medicaid, it is the prescriber's responsibility to provide a pharmacy with the required documentation.

The "Brand Medically Necessary" provisions described for legend drugs do not apply to covered OTC drugs. Medicaid coverage for OTC drugs is limited to generic drugs except for the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies.

Prescribing Drugs Manufactured by Companies Who Have Not Signed the Rebate Agreement

Drug manufacturers who choose to participate in state Medicaid programs are required to sign a rebate agreement with the federal Centers for Medicare and Medicaid Services (CMS), formerly HCFA, under the drug rebate program. By signing the rebate agreement, the manufacturer agrees to pay Wisconsin Medicaid a rebate equal to a percentage of its "sales" to Wisconsin Medicaid.

Wisconsin Medicaid does not cover drugs of companies choosing not to sign the rebate agreement with few exceptions. A Medicaid-certified pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement. In addition, providers may refer to the Pharmacy Data Tables section of the Pharmacy Handbook for a list. Providers may reference the Pharmacy Handbook on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Wisconsin Medicaid recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer who did not sign a rebate agreement. These drugs may be covered when the ***pharmacy*** obtains PA.

In this situation, the ***prescriber*** must provide the following documentation to the pharmacy:

- A statement indicating that no other drug produced by a manufacturer that signed the rebate agreement is medically appropriate for the recipient.
- A statement indicating that Medicaid reimbursement of the drug would be cost effective for Wisconsin Medicaid.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber documenting medical necessity.

Drug Utilization Review System

The federal Omnibus Budget Reconciliation Act of 1990 (42 CFR Parts 456.703 and 456.705) called for a Drug Utilization Review (DUR) program for all Medicaid outpatient drugs to improve the quality and cost-effectiveness of recipient care. Wisconsin Medicaid's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. The DUR system checks the recipient's entire drug history regardless of where the drug was dispensed or by whom it was prescribed. This allows prescribers to be alerted to current medication(s) the recipient is taking that may interact with a new prescription.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber documenting medical necessity.

Prospective Drug Utilizations Review's Impact on Prescribers

Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers. If a pharmacist receives an alert, a response is required before the drug can be dispensed to the recipient. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription

should be filled as written, modified, or cancelled.

The prospective DUR system does not dictate which drugs are dispensed; prescribers and pharmacists must exercise professional judgement, and will still have the freedom to do so.

Diagnoses from medical claims are used to build a medical profile for each recipient. The prospective DUR system uses this profile to determine whether a prescribed drug may be inappropriate or harmful to the recipient. It is very important that prescribers provide up-to-date medical diagnosis information on recipients' medical claims to ensure complete and accurate recipient profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs are dispensed; prescribers and pharmacists must exercise professional judgement, and will still have the freedom to do so.

Prescriptions for Disposable Medical Supplies and Durable Medical Equipment

A physician, physician assistant, or nurse practitioner must prescribe Medicaid-covered durable medical equipment (DME) and disposable medical supplies (DMS) so that the Medicaid-certified DME or DMS provider is reimbursed by Wisconsin Medicaid. All DME and DMS require a physician or physician assistant prescription except for the following DMS:

- Hearing instrument batteries.
- Hearing instrument accessories.
- Hearing instrument repairs.

Breast Pumps

Wisconsin Medicaid reimburses for the prescribing of breast pumps as part of an Evaluation and Management (E&M) office visit. Physicians are required to document clinical requirements of an individual's need for a breast pump. Wisconsin Medicaid requires the following criteria be met:

- The recipient recently delivered a baby and a physician has ordered or recommended mother's breast milk for the infant.
- Documentation indicates there is the potential for adequate milk production.
- Documentation indicates there is a long-term need for and planned use of the breast pump to obtain a milk supply for the infant.
- The recipient is capable of being trained to use the breast pump as indicated by the physician or provider.
- Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breastfeeding difficult or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

Refer to Appendix 11 of this section for a copy of the optional Breast Pump Order form that the prescribing provider may complete.

Physicians or nurse practitioners may prescribe breast pumps for recipients, which can then be obtained through a Medicaid-certified DME provider or pharmacy. Wisconsin Medicaid does not reimburse providers for supplying breast pumps, unless they are also Medicaid certified as a DME provider or pharmacy.

Prescriptions for Specialized Medical Vehicle Services

Physician Certification Form

Wisconsin Medicaid reimburses specialized medical vehicle (SMV) providers for necessary transportation of eligible recipients to and from Medicaid-covered services. To be eligible for SMV services, a recipient must be temporarily or indefinitely physically or

mentally disabled ***and*** must have conditions that contraindicate common carrier (i.e., private vehicle, taxi, or bus) transportation.

If a recipient has disabilities and has conditions that contraindicate common carrier transportation, a physician, physician assistant, nurse midwife, or nurse practitioner should complete an SMV Transportation Physician Certification form to certify the recipient's coverage for SMV transportation. Refer to Appendix 32 of this section for a copy of this form.

Inconvenience or lack of timely transportation are not valid justifications for the use of SMV transportation. The presence of a disability, whether physical or mental, does not by itself justify SMV transportation.

When completing the SMV Transportation Physician Certification form, be certain to identify:

- The recipient's specific medical problem and the appropriate diagnosis code.
- The reason the recipient's condition contraindicated transport by a common carrier.
- The length of time SMV transportation is needed.

The medical provider gives the completed form to the recipient who then gives the form to the SMV provider. The medical provider does not need to keep a copy of the completed form on file, but must document the medical condition necessitating SMV transportation in the recipient's medical record.

Physicians must complete a new form upon expiration. For recipients with permanent disabilities, the form must be renewed every 365 days. For recipients with temporary disabilities, it must be renewed upon expiration, not exceeding every 90 days.

If the recipient does not meet the criteria for coverage, the medical provider may write "Not Certified" on the form or simply choose not to complete the form.

Medical providers must not complete the forms retroactively for SMV providers or recipients.

Providers may not charge recipients for completing the form. Wisconsin Medicaid will reimburse providers at the lowest level E&M *Current Procedural Terminology* procedure code if the recipient is in the office when the form is completed and no other medical service is provided.

Specialized Medical Vehicle Trips Exceeding One-Way Upper Mileage Limits

Wisconsin Medicaid requires a prescription for SMV trips that exceed Wisconsin Medicaid's one-way mileage limits. (This prescription is required in addition to the SMV Transportation Physician Certification form.) A physician or physician assistant referring an SMV-eligible recipient to a Medicaid-covered health service that is farther than the upper mileage limit must write a prescription for the recipient to give to the SMV provider.

Wisconsin Medicaid requires a prescription for SMV trips that exceed Wisconsin Medicaid's one-way mileage limits.

Wisconsin Medicaid one-way upper mileage limits are:

- 40 miles or more, if the trip originates in one of these urban counties:

Brown	Dane
Fond du Lac	Kenosha
La Crosse	Manitowoc
Milwaukee	Outagamie
Sheboygan	Racine
Rock	Winnebago

- 70 miles or more, if the trip originates in ***any other*** Wisconsin county.

The prescription must be renewed upon expiration and must include the following:

- Name of the health care provider or facility, and the city in which it is located.
- The service being provided.
- The length of time the recipient will need the service (not to exceed 365 days).

Billing and Reimbursement

Claims Submission Deadline

Wisconsin Medicaid must receive properly completed claims for services provided to eligible recipients within 365 days from the date of service (DOS). This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Wisconsin Medicaid must receive properly completed claims for services provided to eligible recipients within 365 days from the date of service (DOS).

Exceptions to the 365-day claims submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may obtain copies of the handbook at *www.dhfs.state.wi.us/medicaid/* or by calling Provider Services at (800) 947-9627 or (608) 221-9883.

Electronic Billing

Wisconsin Medicaid processes claims that providers submit on magnetic tape (tape-to-tape) or via modem. All claims that providers submit, whether electronic or paper, are subject to the same Medicaid processing and legal requirements. Electronic claims submission usually reduces claim errors.

Wisconsin Medicaid provides software for billing electronically. If interested in billing electronically, please call the Electronic Media Claims (EMC) Department at (608) 221-4746 and ask to speak to an EMC coordinator to request the appropriate information. For technical questions about the EZ-Link software, please call (800) 822-8050.

All physician medicine and surgery services may be billed electronically except when billing an "unlisted" (nonspecific) procedure code or when documentation must be submitted with the claim. In these instances, providers must submit their claims on the paper CMS 1500 claim form with appropriate documentation.

CMS 1500 Claim Form

Physicians submitting paper claims must use the CMS 1500 claim form dated 12/90. Wisconsin Medicaid denies claims for physician services submitted on any other paper claim form than the CMS 1500 claim form. Refer to Appendix 4 of this section for CMS 1500 claim form completion instructions. Refer to Appendices 5 and 6 for sample completed CMS 1500 claim forms for physician services.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal forms supplier.

Where to Send Your Claims

Mail completed CMS 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Mother/Baby Claims

A "mother/baby" claim is a claim that a provider submits for services provided for a baby under the mother's Medicaid identification number. (The mother's services are not reimbursed on the mother/baby claim, only the baby's services.) Wisconsin Medicaid reimburses only services provided to the baby during the baby's first 10 days of life under the mother's number.

Hospitals, physicians, nurse practitioners, nurse midwives, and Medicaid HMOs are required to promptly report the birth of a newborn to a mother who is Medicaid-eligible to Wisconsin Medicaid so that the newborn's eligibility for Wisconsin Medicaid may be established as soon as possible.

After the baby's eligibility is established and Wisconsin Medicaid has issued a temporary identification number for the baby, providers should submit the baby's claims using the temporary identification number, rather than using the mother's identification number.

To obtain recipients' identification numbers, contact Medicaid's Eligibility Verification System (EVS) or refer to the recipient's Medicaid identification card. For more information on the EVS, refer to the Important Numbers page in the beginning of this section or the Provider Resources section of the All-Provider Handbook.

For specific instructions on completing a claim form as a mother/baby claim, refer to Appendix 4 of this section.

Medicaid-Allowable Procedure Codes

Use the Most Appropriate Code

Use the single five-character *Current Procedural Terminology* (CPT) procedure code, Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System, code or local procedure code that best describes the service provided. Wisconsin Medicaid denies claims received without an appropriate CPT, HCPCS, or local code. Refer to Appendices 1 and 3 of this section for procedure codes that Wisconsin Medicaid covers for physicians and physician clinics.

Do not bill multiple procedure codes to describe a single service that was provided. Claims are monitored by McKesson ClaimCheck®, Medicaid's procedure coding review software, to avoid reimbursement of duplicate or redundant services.

Current CPT and HCPCS Codes

Wisconsin Medicaid does not allow reimbursement for all CPT or HCPCS codes (e.g., fertility-related services are not covered). Other CPT and HCPCS codes have limitations (e.g., require prior authorization). Generally, Wisconsin Medicaid coverage is consistent with the procedure code descriptions given in CPT and HCPCS. Therefore, providers must use the appropriate provider handbook in conjunction with the most current CPT and HCPCS books.

Local Procedure Codes

Wisconsin Medicaid establishes local codes for certain new procedures (e.g., W6020 — infant molding headbands) or for procedure codes unique to Wisconsin (e.g., W6271 — directly observed preventive therapy, TB infected only). These local codes are only valid for Wisconsin Medicaid. Refer to Appendix 3 of this section for Wisconsin Medicaid Local Procedure Codes.

Unlisted Procedure Codes

Medicaid claims for an unlisted (nonspecific) procedure code require documentation describing the procedure performed. If the procedure can be described in a few words, you may use Element 19 ("Reserved for Local Use") of the CMS 1500 claim form.

If this space is not sufficient, write "see attached" in Element 19 and attach additional documentation describing in detail the procedure or service. The documentation must also be sufficient to allow the chief Medicaid medical officer to determine the nature and scope of the procedure and whether the procedure was medically necessary as defined in Wisconsin Administrative Code.

Generally, Wisconsin Medicaid coverage is consistent with the procedure code descriptions given in CPT and HCPCS. Therefore, providers must use the appropriate provider handbook in conjunction with the most current CPT and HCPCS books.

Billed Amounts

The maximum allowable fee is the amount that Wisconsin Medicaid will pay a provider for an allowable procedure code.

Providers are to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median (i.e., 50% of charges are above and 50% are below) of the individual providers' charge for the service when provided to non-Medicaid patients.

Under s. 49.43(1m), Wis. Stats., "charge" means "the customary, usual and reasonable demand for payment as established prospectively, concurrently or retrospectively," which may not "exceed the general level of charges by others who render such service or care, or provide such commodities, under similar or comparable circumstances within the community in which the charge is incurred."

For providers who have not established usual and customary charges, Medicaid charges should be reasonably related to the provider's cost to provide the services.

Terms of Reimbursement Agreement

As part of Wisconsin Medicaid certification, providers sign an agreement to:

- Submit claims to Wisconsin Medicaid in accordance with Wisconsin Medicaid requirements, including billing usual and customary charges by most providers.
- Accept Wisconsin Medicaid's Terms of Reimbursement, as defined in their Wisconsin Medicaid certification packet.

Reimbursement

Maximum Allowable Fees

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. (Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee for the procedure.) Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted to Wisconsin Medicaid, the Wisconsin State Legislature's budgetary constraints, and other relevant economic limitations.

Providers are encouraged to obtain a schedule of Wisconsin Medicaid maximum allowable fees for physician services from one of the following sources:

- An electronic version on Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.
- Purchase a paper copy by:
  - ✓ Writing to the following address:

    Wisconsin Medicaid
    Provider Maintenance
    6406 Bridge Rd
    Madison WI 53784-0006

  - ✓ Calling Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.

Maximum Daily Reimbursement

A provider's reimbursement for all services performed on the same DOS for the same recipient may not exceed the amount established by Wisconsin Medicaid, except for services lasting over six hours. As of July 1, 2002, the maximum amount is $2,308.43. Provider reimbursement potentially exceeding this amount is limited to the maximum amount and a message appears on the Remittance and Status (R/S) Report informing the provider of the limit.

A service exceeding six hours must first be billed to Wisconsin Medicaid in the usual manner. After the reimbursement is received, additional reimbursement may be requested by submitting an Adjustment Request Form ***with a copy of the anesthesia record*** to Wisconsin Medicaid. Refer to the Claims Submission

section of the All-Provider Handbook for a sample Adjustment Request Form and completion instructions.

Medicaid Payment

Wisconsin Medicaid reimburses fee-for-service providers the lesser of the following:

- Medicaid's maximum allowable fee for the service.
- The provider's billed amount.

Reimbursement for Various Types of Providers

Physicians

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

Teaching Programs: Interns, Residents, and Supervising Physicians

Wisconsin Medicaid reimburses supervising physicians in a teaching setting for the services provided by interns and residents, if those services are supervised, provided as part of the training program, and billed under the supervising physician's provider number. The supervising physician must provide personal and identifiable direction to interns or residents who are participating in the care of the recipient. This direction includes any or all of the following:

- Reviewing the recipient's medical history or physical examination.
- Personally examining the recipient within a reasonable period after admission.
- Confirming or revising diagnoses.
- Determining the course of treatment to be followed.
- Making frequent review of the recipient's progress.

The notes must indicate that the supervising physician personally reviewed the recipient's medical history, performed a physical and/or psychiatric examination, confirmed or revised the diagnosis, visited the recipient during the more critical period of illness, and discharged the recipient.

Residents

Wisconsin Medicaid reimburses residents for physician services when:

- The resident is fully licensed to practice medicine and has obtained a Medicaid provider number.
- The service can be separately identified from those services that are required as part of the training program.
- The resident is operating independently and not under the direct supervision of a physician.
- The service is provided in a clinic, an outpatient hospital, or emergency department setting.

The reimbursement for residents is identical to other licensed physicians.

Physician Assistants

Wisconsin Medicaid generally reimburses physician assistants 90% of the payment allowed for the physician who would have otherwise performed the service. Physician assistants, however, are paid 100% of the physician's maximum fee for HealthCheck screens, injections, immunizations, lab handling fees, and select diagnostic procedures.

Nurse Practitioners

Nurse practitioners receive the same reimbursement as physicians for services.

Ancillary Providers

Services provided by ancillary providers (e.g., dietician counselors, nutritionists, health educators, genetic counselors, and nurse practitioners who are not Medicaid certifiable) are only reimbursed if provided under the ***direct, immediate, on-site*** supervision of a physician as part of a physician evaluation and

Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.

management (E&M) visit. (Nurse practitioners, nurse midwives, and anesthetists who are Medicaid certified should refer to their own Medicaid publications for billing information.)

"On-site" means that the supervising physician is in the same office or suite in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention. The physician is not required to be in the same room as the ancillary provider, unless dictated by medical necessity and good medical practice.

Submit claims for services performed by ancillary providers under the supervising physician's provider number using the appropriate CPT code.

Surgical procedures performed by the same physician, for the same recipient, on the same DOS, must be submitted on the same claim form.

Reimbursement for Surgical Procedures

Surgical procedures performed by the same physician, for the same recipient, on the same DOS, must be submitted on the same claim form. Surgeries that are billed on separate claim forms are denied.

Reimbursement for most surgical procedures includes reimbursement for preoperative and postoperative care days. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

Although E&M services pertaining to the surgery for DOS during the preoperative and postoperative care days are not covered, an E&M service may be reimbursed if it was in response to a different diagnosis.

Reimbursement for Special Circumstances of Surgery

Co-surgeons

Wisconsin Medicaid reimburses each surgeon at 100% of Wisconsin Medicaid's usual surgeon rate for the specific procedure he or she has performed. Attach documentation (such as an operative report) clearly marked "co-surgeon" to each surgeon's claim form to demonstrate medical necessity.

Surgical Assistance

Wisconsin Medicaid reimburses for surgical assistance at 20% of the maximum allowable fee for the surgical procedure. To receive reimbursement for surgical assistance, bill the surgery procedure code with type of service (TOS) code "8" in Element 24C of the CMS 1500 claim form. Wisconsin Medicaid reimburses surgical assistance only for those surgeries that are listed in the Physician Services Maximum Allowable Fee Schedule with a TOS "8."

Physician assistants who perform as surgical assistants receive 90% of the TOS "8" maximum allowable fee for the surgery.

Bilateral Surgeries

Bilateral surgical procedures are paid at 150% of the maximum fee for the single service. Indicate modifier "50" in Element 24D and a quantity of "1.0" in Element 24G of the CMS 1500 claim form.

Multiple Surgeries

Multiple surgical procedures performed by the same physician for the same recipient during the same surgical session are reimbursed at 100% of the maximum allowable fee for the primary procedure, 50% for the secondary procedure, 25% for the tertiary procedure, and 13% for all subsequent procedures. The Medicaid-allowed surgery with the greatest usual and customary charge on the claim is reimbursed as the primary surgical procedure, the next highest as the secondary surgical procedure, etc.

Wisconsin Medicaid permits full maximum allowable payments for surgeries that are performed on the same DOS but at ***different*** surgical sessions. For example, if a provider performs a sterilization on the same DOS as a

delivery, the provider may be reimbursed the full maximum allowable fee for both surgeries if the surgeries were performed at different surgical sessions (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same day that are being billed under the recipient's number. After the claim is reimbursed, submit an Adjustment Request Form for the paid claim with documentation clarifying that the surgeries were performed in separate surgical sessions. Refer to the Claims Submission section of the All-Provider Handbook for a sample Adjustment Request Form and completion instructions.

Note: Most diagnostic and certain vascular injection and radiological procedures are not subject to the multiple surgery reimbursement limits. Call Provider Services at (800) 947-9627 or (608) 221-9883 for more information on whether a specific procedure code is subject to these reimbursement limits.

Multiple Births

Reimbursement for multiple births is dependent on the circumstances of the deliveries. If all deliveries are vaginal or if all are cesarean, the first delivery is reimbursed at 100% of Medicaid's maximum allowable fee for the service. The second delivery is reimbursed at 50%, the third at 25%, and subsequent deliveries at 13% each.

In the event of a combination of vaginal and cesarean section deliveries, the delivery with the largest billed amount is reimbursed at 100%, the delivery with the next largest at 50%, and so on, consistent with the policy for other situations of multiple surgeries.

For example, if the initial delivery of triplets is vaginal and the subsequent two deliveries are C-sections, the first C-section delivery is reimbursed at 100%, the second C-section delivery at 50%, and the vaginal delivery at 25%.

Pre- and Postoperative Care

Reimbursement for certain surgical procedures frequently includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For the number of preoperative and postoperative care days on file for a specific procedure code, call Provider Services at (800) 947-9627 or (608) 221-9883. This information is also available to providers who have access to the Direct Information Access Line with Updates for Providers (Dial-Up). For more information about Dial-Up, including technical requirements and fees, call the EMC Department at (608) 221-4746.

Enhanced Reimbursements

Pediatric Services

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for recipients 18 years of age and under. The enhanced reimbursement rates are indicated on the Physician Services Maximum Allowable Fee Schedule.

To obtain the enhanced reimbursement for recipients under 18 years old, indicate one of the applicable procedure codes and the modifier "PD" in Element 24D of the CMS 1500 claim form.

Wisconsin Medicaid provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for recipients 18 years of age and under.

Health Personnel Shortage Area

Wisconsin Medicaid provides enhanced reimbursement to primary care providers when one or both of the following apply:

- The performing or billing provider is located in a Health Personnel Shortage

Area (HPSA)-eligible ZIP code.
- The recipient has a residential address (according to Medicaid's eligibility records) within a HPSA-eligible ZIP code.

Primary care providers, all of whom must be Medicaid-certified, include the following:

- Nurse midwives.
- Nurse practitioners.
- Physician assistants.
- Physicians with specialties of general practice, OB-GYN, family practice, internal medicine, or pediatrics.

The incentive payment for HPSA-eligible primary care procedures is an additional 20% of the physician maximum allowable fee.

The incentive payment for HPSA-eligible primary care procedures is an additional 20% of the physician maximum allowable fee. Health Personnel Shortage Area-eligible ***obstetrical*** procedures receive the additional 20% and then that amount is increased by another 25%.

Refer to Appendix 27 of this section for a list of HPSA-eligible procedure codes and ZIP codes.

To obtain the HPSA-enhanced reimbursement, indicate in Element 24D of the CMS 1500 claim form one of the following modifiers:

- "HK" for HPSA/Child (18 years of age and under).
- "HP" for HPSA/Adult (over 18 years of age).

Reimbursement for eligible procedure codes billed with the "HK" modifier includes the pediatric incentive payment. Do not bill "HK" and "PD" modifiers for the same procedure code. The "PD" modifier can be billed for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.

Certified HealthCheck providers performing preventive visits (procedure codes 99381-99385 and 99391-99395) for recipients under age 21 are eligible for either HPSA or HealthCheck incentive payments.

Reimbursement is greater for HealthCheck screens than for preventive visits eligible for HPSA bonuses. Providers may receive only one of the bonuses.

If the preventive visit is a qualified HealthCheck screen, providers should use the appropriate HealthCheck modifier instead of the HPSA modifier. If the visit does not qualify as a HealthCheck screen but meets the HPSA requirement, the provider should use the appropriate HPSA modifier. If both HPSA and HealthCheck modifiers are used, Medicaid will pay the greater of the two incentive payments. For more information about HealthCheck services, refer to the HealthCheck Handbook.

Monitoring Medicaid Policy

Wisconsin Medicaid monitors claims for compliance with Medicaid reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. This software reviews claims submitted to Wisconsin Medicaid for billing inconsistencies and errors with respect to CPT codes.

ClaimCheck review may affect claims in one of the following ways:

1. The claim is unchanged by the review.
2. The procedure codes are rebundled into one or more appropriate codes.
3. One or more of the codes is denied as incidental/integral or mutually exclusive.

ClaimCheck monitors the following Medicaid policy areas:

1. *Unbundling (Code Splitting)*
   Unbundling occurs when two or more CPT codes are used to describe a procedure that may be better described by a single, more comprehensive code. ClaimCheck considers the single, most appropriate code for reimbursement when unbundling is detected.

If you bill certain procedure codes separately, ClaimCheck rebundles them into the single, most appropriate panel. For example, if you bill two procedure codes for layer closure of wounds, 12.6 cm to 20.0 cm and 20.1 cm to 30.0 cm (procedure codes 12035 and 12036), ClaimCheck rebundles them to layer closure of wounds over 30.0 cm (procedure code 12037).

ClaimCheck totals billed amounts for individual procedures. For example, if you bill three procedures at $20, $30, and $25, ClaimCheck rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for that rebundled code at $75. However, Wisconsin Medicaid reimburses you either the lesser of the billed amount or the maximum allowable fee for that procedure code.

2. *Incidental/Integral Procedures*
   Incidental procedures are those procedures performed at the same time as a more complex primary procedure. They require few additional physician resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during a hysterectomy surgery.

   Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a recipient undergoes a transurethral incision of the prostate (procedure code 52000), the cystourethroscopy is considered integral to the performance of the prostate procedure.

   When a procedure is either incidental or integral to a major procedure, ClaimCheck considers only the *primary* procedure for reimbursement.

3. *Mutually Exclusive Procedures*
   Mutually exclusive procedures are procedures that would not be performed on a single recipient during the same operative session or that use different codes to describe the same type of procedure.

   For example, a vaginal hysterectomy (procedure code 58260) and a total abdominal hysterectomy (procedure code 58150) are mutually exclusive — either one or the other, but not both procedures are performed.

   When two or more procedures are mutually exclusive, Wisconsin Medicaid reimburses the procedure code with the highest provider-billed amount.

Why Was Payment for a Service Denied by ClaimCheck?

Follow these procedures if you are uncertain about why particular services on a claim were denied:

1. Review the Explanation of Benefits denial code included on the R/S Report for the specific reason for the denial.
2. Review the claim submitted to ensure all information is accurate and complete.
3. Consult current CPT publications to make sure proper coding instructions were followed.
4. Consult this handbook section and other current Wisconsin Medicaid publications to make sure current policy and billing instructions were followed.
5. Contact Medicaid Provider Services at (800) 947-9627 or (608) 221-9883 for further information or explanation.
6. If circumstances warrant an exception, submit an Adjustment Request Form with supporting documentation and the words "medical consultant review requested" written on the form.

ClaimCheck totals billed amounts for individual procedures.

Follow-Up to Claims Submission

Providers, not Wisconsin Medicaid, initiate follow-up procedures on Medicaid claims. Processed claims appear on the R/S Report either as paid, pending, or denied. Wisconsin Medicaid takes no further action on a denied claim unless the provider corrects the information and resubmits the claim for processing.

If a claim is paid incorrectly, the provider must submit an Adjustment Request Form to Wisconsin Medicaid.

If a claim is paid incorrectly, the provider must submit an Adjustment Request Form to Wisconsin Medicaid. The Claims Submission section of the All-Provider Handbook includes detailed information regarding:

- The R/S Report. Remittance and Status messages are posted on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.
- Adjustments to paid claims.
- Overpayments.

Appendix

Appendix 1

Wisconsin Medicaid-Allowable CPT Codes for Physician Evaluation and Management, Medicine, and Surgical Services

Some procedure codes displayed within ranges below may not be covered by Wisconsin Medicaid. Consult the Physician Services Maximum Allowable Fee Schedule or call Provider Services at (800) 947-9627 or (608) 221-9883 regarding coverage of specific procedure and type of service (TOS) code combinations. The following charts are periodically revised. Refer to the other sections of the Physician Services Handbook for anesthesia, laboratory, and radiology procedure codes. Refer to Appendix 2 of this section for applicable TOS codes and descriptions.

Service	*Current Procedural Terminology* (CPT) Procedure Codes	TOS
Evaluation and Management Services		
Office or Other Outpatient Services	99201-99215	1
Hospital Observation Services	99217-99220	1
Hospital Inpatient Services	99221-99239	1
Consultations	99241-99275	3
Emergency Department Services	99281-99288	1
Critical Care Services	99291-99292	1
Neonatal Intensive Care	99295-99298	1
Nursing Facility Services	99301-99316	1
Domiciliary, Rest Home, or Custodial Care Services	99321-99333	1
Home Services	99341-99350	1
Prolonged Services	99354-99357, 99360	1
Preventive Medicine Services	99381-99397, 99429	1
Newborn Care	99431-99440	1
Other Evaluation and Management Services	99499	1
Surgery Services		
General	10021-10022	2
Integumentary System	10040-19499	2, 8
Musculoskeletal System	20000-29999	2, 8
Respiratory System	30000-32999	2, 8
Cardiovascular System	33010-37799	2, 8
Hemic and Lymphatic Systems	38100-38999	2, 8
Mediastinum and Diaphragm	39000-39599	2, 8

Appendix 1
(Continued)

Service	CPT Procedure Codes	TOS
Surgery Services (Continued)		
Digestive System	40490-49999	2, 8
Urinary System	50010-53899	2, 8
Male Genital System	54000-55899	2, 8
Female Genital System	56405-58999	2, 8
Maternity Care and Delivery	59000-59899	2, 8
Endocrine System	60000-60699	2, 8
Nervous System	61000-64999	2, 8
Eye and Ocular Adnexa	65091-68899	2, 8
Auditory System	69000-69979	2, 8
Note: Assistance at surgery (TOS "8") is allowed for those procedures recognized as accepted medical practice. Refer to the Physicians' Maximum Allowable Fee Schedule.		
Refer to the **Laboratory and Radiology section** of the **Physician Services Handbook** for Medicaid allowable laboratory (CPT codes 80048-89399 and HCPCS) and radiology (CPT codes 70010-79999 and HCPCS) procedure codes.		
Medicine Services		
Immune Globulins	90281-90399	1
Vaccines, Toxoids	90476-90749	1
Therapeutic or Diagnostic Infusions	90780-90781	1
Therapeutic, Prophylactic or Diagnostic Injections	90782-90799	1
Psychiatry	90862	1
	Refer to the Mental Health and Other Drug Abuse Services Handbook, and related *Wisconsin Medicaid and BadgerCare Updates* for covered services and related limitations for information on other psychiatric services coverage.	
Biofeedback	90901-90911	1
Dialysis	90918-90925	M
	90935-90999	1
Gastroenterology	91000-91065	B, U, W
	91100-91105	1
	91122	B, U, W
	91123	1
	91132-91299	B, U, W

Appendix 1
(Continued)

Service	CPT Procedure Codes	TOS
Medicine Services (Continued)		
Ophthalmology	Refer to the Vision Care Services Handbook, and to related *Updates* for more information about covered services and related limitations.	
	92002-92020	1
	92060	B, U, W
	92065-92070	1
	92081-92083	B, U, W
	92100-92130	1
	92135-92136	B, U, W
	92140-92230	1
	92235-92250	B, U, W
	92260	1
	92265-92287	B, U, W
	92499	1, B, U, W
Special Otorhinolaryngologic Services	92502-92526	1
	92531-92548	B, U, W
	92551-92584	1
	92585-92588	B, U, W
	92589	1
	92590-92593	B
	92599	1, B
Cardiovascular	92950-92974	1
	92975	B, U, W
	92977	1
	92978-92979	B, U, W
	92980-92998	2, 8
	93000	B
	93005	U
	93010	W
	93012	U
	93014	W
	93015	B
	93016	1
	93017	U
	93018	W

Appendix 1
(Continued)

Service	CPT Procedure Codes	TOS
Medicine Services (Continued)		
Cardiovascular (Continued)	93024-93025	B, U, W
	93040	B
	93041	U
	93042	W
	93224	B
	93225-93226	U
	93227	W
	93230	B
	93231-93232	U
	93233	W
	93235	B
	93236	U
	93237	W
	93268	B
	93270-93271	U
	93272	W
	93278-93313	B, U, W
	93314	W
	93315	B, U, W
	93316-93317	W
	93318-93501	B, U, W
	93503	W
	93505-93533	B, U, W
	93539-93545	2
	93555-93662	B, U, W
	93720	B
	93721	U
	93722	W
	93724-93770	B, U, W
	93784	B
	93786-93788	U
	93790	W
	93797-93798	1
	93799	1, B, U, W

Appendix 1
(Continued)

Service	CPT Procedure Codes	TOS
Medicine Services (Continued)		
Non-Invasive Vascular Diagnostic Studies	93875-93990	B, U, W
Pulmonary	94010	B, U, W
	94014	B
	94015	U
	94016	W
	94060-94621	B, U, W
	94640-94668	1
	94680-94750	B, U, W
	94760	B
	94770-94772	B, U, W
	94799	1, B, U, W
Allergy and Clinical Immunology	95004-95199	1
Neurology and Neuromuscular Procedures	95805-95829	B, U, W
	95830-95857	1
	95858-95962	B, U, W
	95965-95967	W
	95970-95975	B, U, W
	95999	1, B, U, W
	96000-96003	U
	96004	W
Central Nervous System Assessments/Tests	96100-96117	1
Chemotherapy Administration	96400-96542, 96549	1
Photodynamic Therapy	96567-96571	1
Special Dermatological Procedures	96900, 96910-96999	1
Physicial Medicine and Rehabilitation	97001-97004, 97010-97542	1
Osteopathic Manipulative Treatment	98925-98929	1
Special Services Procedures and Reports	99000-99001	5
	99070	1
Other Services Procedures	99170, 99173, 99183-99199	1

Appendix 1
(Continued)

Service	Health Care Procedure Coding System* Procedure Codes	TOS
Procedures/ Professional Services	G0002	2
	G0004	B
	G0005	U
	G0006	B
	G0007	W
	G0015	U
	G0025	B
	G0101-G0102	1
	G0104-G0106	2
	G0117-G0118	1
	G0120-G0122	2
	G0166	2
	G0185-G0187	2
	G0193	2
	G0194	B, U, W
	G0195-G0201	1
Temporary Codes	Q0035	B, U, W
	Q0081-Q0085, Q0136	1
	Q0163-Q0172, Q0174-Q0180	1
	Q0183-Q0187	9
	Q2001-Q2022	1
	Q3001-Q3012	9
	Q4001-Q4051	P
Private Payer Codes	S0009, S0016-S0088, S0091-S0093, S0155-S0191	1
	S0820	B, U, W
	S2053-S2055, S2112-S2115	2, 8
	S2120	1
	S2140	2
	S2300	2, 8
	S2341	2
	S2350-S2361, S2400-S2411	2, 8
	S8950, S9055	1

*Formerly HCFA Common Procedure Coding System.

Appendix 2

Medicaid Type of Service and Place of Service Codes

Type of Service	Description
1	Medical care, injections, HealthCheck (EPSDT)
2	Surgery
3	Consultations
5	Diagnostic Lab (total charge) HealthCheck Lab
8	Assistant surgery
9	Other
B	Diagnostic testing, diagnostic medical services — total or complete procedure including professional and technical components
M	Alternate Payment — Dialysis
U	Diagnostic testing, diagnostic medical services — technical component only
W	Diagnostic testing, diagnostic medical services — professional component only (interpretation)

Place of Service	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance
B	Ambulatory Surgical Center

Appendix 3

Wisconsin Medicaid Local Procedure Codes

Procedure Code	Description
Clozapine Management (TOS* "1")	
W8902	Clozapine management — no face-to-face
W8903	Clozapine management — at office or at a multiple recipient off-site location
W8904	Clozapine management — at home or other single recipient site
Surgery Procedure Codes (TOS "2")	
W6000	Antepartum care; initial visit
W6001	Antepartum care; two or three visits
W6020	Infant head molding bands
Tuberculosis-Related Procedure Codes (TOS "1")	
W6175	Tine/Mantoux/PPD
W6271	Directly observed preventive therapy — TB infected only
W6272	Monitoring of TB symptoms — TB infected only
W6273	Patient education and anticipatory guidance — TB infected only
W6274	Direct observation of therapy — suspect or confirmed active TB case
W6275	Monitoring of TB symptoms — suspect or confirmed active TB case
W6276	Patient education and anticipatory guidance — suspect or confirmed active TB case
Other Procedure Codes (TOS "1")	
W6200	Intrauterine device — progesterone
Injection Procedure Codes (TOS "1")	
W6100	Injection, ACTH Gel, 80 units
W6102	Injection, ampicillin, 1 gram
W6104	Injection, bicillin C-R, (900/300)
W6105	Injection, bicillin C-R, up to 300,000 units
W6106	Injection, calcimar, 100 units
W6107	Injection, calcimar, 200 units
W6109	Injection, calcium chloride, 10 ml
W6110	Injection, cleocin, up to 600 mg
W6112	Injection, cortrosyn, 0.25 mg
W6114	Injection, depo-medrol, 60 mg
W6115	Injection, depo-medrol, 120 mg
W6116	Injection, depo-provera, 250 mg
W6117	Depo-medroxyprogesterone, 150 mg
W6118	Injection, depo-testosterone, 300 mg
W6119	Injection, depo-testosterone, 400 mg
W6120	Injection, dexamethasone, LA 8 mg/ml
W6121	Injection, dexamethasone, LA 16 mg
W6122	Injection, dextrose, 50 ml
W6124	Injection, ephedrine
W6126	Injection, furosemide, 20 mg
W6127	Injection, furosemide, 40 mg
W6128	Injection, furosemide, 80 mg
W6130	Injection, glucagon, 1 mg
W6134	Injection, heparin, 10,000 units
W6136	Injection, heparin, 20,000 units
W6137	Injection, heparin, 5,000 units

Procedure Code	Description
Injection Procedure Codes (TOS "1") (Continued)	
W6138	Injection, hydrocortisone, 250 mg
W6140	Injection, imferon, 1 ml
W6141	Injection, imferon, 3 ml
W6142	Injection, isoproterenol
W6144	Injection, kantrex 1 gm
W6146	Injection, kefzol 1 gm
W6148	Injection, magnesium sulfate
W6152	Injection, nubain
W6156	Injection, penicillin G procaine, 900,000 units
W6157	Injection, penicillin G procaine, 1.2 mil units
W6158	Injection, penicillin G procaine, 2.4 mil units
W6159	Injection, penicillin G procaine, 4.8 mil units
W6160	Injection, penicillin G procaine, 2.4 mil units/probe
W6161	Injection, penicillin G procaine, 4.8 mil units/probe
W6162	Injection, procaine
W6164	Injection, prolixin decanoate, 50 mg
W6166	Injection, prolixin enanthate, 25 mg
W6167	Injection, prolixin enanthate, 50 mg
W6168	Injection, stadol
W6170	Injection, susphrine
W6172	Injection, tensilon, 5 mg
W6173	Injection, terramycin, 100 mg
W6177	Injection, velban, 2 mg
W6178	Injection, velban, 5 mg
W6179	Injection, velosef, 250 mg
W6180	Injection, velosef, 500 mg
W6181	Vistaril, 100 mg

*TOS: Type of Service

Appendix 4

CMS 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should ***always*** verify recipient eligibility before providing services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Commercial insurance (private insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service is not covered by insurance as determined by Wisconsin Medicaid.

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, ***and*** the service requires other health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes ***must*** be indicated in the ***first*** box

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To submit a claim for an infant using the mother's Medicaid identification number, enter the following:

Element 1a: Enter the mother's 10-digit Medicaid identification number.

Element 2: Enter the mother's last name followed by "newborn."

Element 3: Enter the ***infant's*** date of birth.

Element 4: Enter the mother's name followed by "mom" in parentheses.

Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Appendix 4
(Continued)

of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, ***or*** payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim was actually billed to the health insurer.
OI-Y	YES, the recipient has health insurance, but it was not billed for reasons including, but not limited to: ✓ Recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ Health insurance failed to respond to initial and follow-up claims. ✓ Benefits not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, ***if applicable****:*

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not provided by a designated or network provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

Appendix 4
(Continued)

If none of the previous statements are true, a Medicare disclaimer code is necessary.

The following Medicare disclaimer codes can be used when appropriate:

Code	Description
M-1	**Medicare benefits exhausted.** This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. • The recipient is eligible for Medicare Part A. • The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. • The recipient is eligible for Medicare Part B. • The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.
M-5	**Provider is not Medicare certified.** *(This code is not applicable to physicians)* This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in these two instances only: *For Medicare Part A* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided. • The recipient is eligible for Medicare Part A. • The procedure provided is covered by Medicare Part A. *For Medicare Part B* (all three criteria must be met): • The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided. • The recipient is eligible for Medicare Part B. • The procedure provided is covered by Medicare Part B.

Appendix 4
(Continued)

M-6 **Recipient not Medicare eligible.** This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 **Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 **Noncovered Medicare service.** This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Appendix 4
(Continued)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be given in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19. Unlisted procedure codes are required to be submitted through paper claims submission. Do not bill unlisted procedure codes through electronic billing.

Element 20 — Outside Lab?

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise this element is not required.

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. The diagnosis description is not required.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number

Enter the seven-digit prior authorization (PA) number from the approved Prior Authorization Request Form (PA/RF). Services authorized under multiple PA requests must be billed on separate claim forms with their respective PA numbers. No other information should be included in this element (e.g., Clinical Laboratory Improvement Amendment number) or the claim will be denied.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if one or all of the following is applicable:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.

Appendix 4
(Continued)

- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. See Appendix 2 of this section for a list of POS codes.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 1 of this section for appropriate procedure/TOS code combinations. See Appendix 2 for a list of TOS codes.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code, Health Care Procedure Coding System (HCPCS), formerly HCFA Common Procedure Coding System code, or local procedure code. Claims received without an appropriate CPT, HCPCS, or local procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D, if appropriate. Medicaid-allowable modifiers include:

Modifier	Definition
50	Bilateral Procedure
PD	Pediatric Patient (18 years of age and under)
HP	Health Personnel Shortage Area/Adult (over 18 years of age on DOS)
HK	Health Personnel Shortage Area/Child (18 years of age or under on DOS)

Note: Wisconsin Medicaid has ***not*** adopted all CPT, HCPCS, or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Plan

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Appendix 4
(Continued)

Element 24I — EMG
Enter an "E" for ***each*** procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use
Enter the eight-digit Medicaid provider number of the performing provider ***for each procedure*** if the billing provider indicated in Element 33 belongs to a physician clinic or group.

Any other information entered in this element may cause claim denial.

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.
Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge
Enter the total charges for this claim.

Element 29 — Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in this element, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare-paid amounts in this field.

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier
The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number. (Physician assistants are not reimbursable as a billing provider.)

Appendix 5

Sample CMS 1500 Claim Form — Physician Medical Services (Three Evaluation and Management Visits with Health Personnel Shortage Area Modifier and Laboratory Handling Fee)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: | STATE:

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 480.0
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	DD DD	3	1	99213	HP	1	XXX XX	3.0				
2 MM DD YY		3	5	99000		1	XX XX	1.0				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.A. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix 6

Sample CMS 1500 Claim Form — Physician Surgical Services (Bilateral Surgery)

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI - P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Attending Physician

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 11223344

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 611.9
2. 724.5
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 1234567

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY		1	2	19318	50	1	XXXX XX	1.0				12345678
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXXX XX

29. AMOUNT PAID $ XXXX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Physician
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Appendix 7

Abortion Certification Statements (for photocopying)

(A copy of the Abortion Certification Statements form is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1161 (Rev. 01/03)

STATE OF WISCONSIN
Section 20.927, Wis. Stats.

WISCONSIN MEDICAID
ABORTION CERTIFICATION STATEMENTS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Coverage Policy
In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, ***and*** provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.

INSTRUCTIONS: When filing a claim for reimbursement of an abortion with Wisconsin Medicaid, physicians must attach a written certification statement attesting to one of the circumstances below. The following are sample certification statements that providers may use to certify the medical necessity of the abortion. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

SECTION I — LIFE OF THE MOTHER

I, _____ , certify that
(Name — Provider)

on the basis of my best clinical judgement, abortion is directly and medically necessary to save the life of

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

for the following reasons:

_____

_____ .

_____ _____
SIGNATURE — Physician Date Signed

Continued on reverse

SECTION II — VICTIM OF RAPE OR INCEST

I, _____ , certify that it is my belief that
(Name — Provider)

_____ , of
(Name — Recipient)

_____ , was the victim of rape (or incest).
(Address — Recipient)

_____ _____
SIGNATURE — Physician Date Signed

SECTION III — GRAVE AND LONG-LASTING DAMAGE TO PHYSICAL HEALTH

I, _____, certify on the basis of
(Name — Provider)

my best clinical judgement that due to an existing medical condition grave, long-lasting physical health damage to

_____ , of
(Name — Recipient)

_____ ,
(Address — Recipient)

would result if the pregnancy were carried to term. The following medical condition necessitates the abortion (specify the medical condition/diagnosis):

_____

_____

_____ _____
SIGNATURE — Physician Date Signed

Appendix 8

Sterilization Informed Consent Instructions and Sample

(A copy of the Sterilization Informed Consent Form Instructions and a sample of the form is located on the following pages.)

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT FORM INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Wisconsin Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is mandatory in order for Wisconsin Medicaid to reimburse providers for services. Any corrections to the form must be signed by the physician and/or recipient, as appropriate. The use of opaque correction fluids on the Sterilization Informed Consent form is prohibited. Instead, strike the incorrect information and initial the corrected information.

CONSENT TO STERILIZATION

The person who obtains the informed consent must provide orally all of the requirements for the informed consent as listed on the consent form, must offer to answer any questions, and must provide a copy of the consent form to the recipient to be sterilized for consideration during the waiting period. (The person obtaining consent need not be the physician performing the procedure.)

Suitable arrangements must be made to ensure that the required information is effectively communicated to the recipient to be sterilized if he or she is blind, deaf, or otherwise handicapped.

Element 1 — Doctor or Clinic (required)
The physician named in Element 1 is not required to match Elements 5 or 23. A recipient may receive information from one doctor/clinic and be sterilized by another. Corrections to this field must be initialed by the person obtaining consent or the physician.

Element 2 — Procedure (required)
The information given in Element 2 must be comparable, but not necessarily identical, to Elements 6, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 3 — Date of Birth (required)
Recipient's date of birth. The month, day, and year must be clearly indicated. Corrections to this field must be lined through and initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 4 — Name of Recipient (required)
The recipient's name must be legible. ***Initials are acceptable for the first and/or middle name only.*** The name may be typed. If this element does not match the signature in Element 7, check the Eligibility Verification System (EVS) to verify that this is the same person. Consider the name in Element 4 to be the valid name. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 5 — Doctor (required)
The name of the doctor, affiliates, or associates is acceptable. The physician in Element 5 is not required to match Element 1 or 23. Corrections to this element must be initialed by the person obtaining consent or the physician. (A consent form *is* transferable and does ***not*** necessitate a new 30-day waiting period.)

Element 6 — Procedure (required)
The information given in Element 6 must be comparable, but not necessarily identical to Elements 2, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Element 7 — Signature (required)
The recipient's signature does not need to ***exactly*** match the name in Element 4. It is unacceptable for the recipient's signature to be ***completely*** different from the name in Element 4. Initials are acceptable for the first and/or middle name. An "X" is acceptable as a signature *if* a witness of the recipient's choice has signed the form. The individual obtaining consent may not act as a witness. There is no field on the form for a witness' signature; it should appear directly below the recipient signature element and be followed by the date of witness, which must match the recipient's signature date in Element 8. Corrections to Element 7 must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

Element 8 — Date (required)
The recipient must be at least 21 years old on this date. If the signature date is the recipient's 21st birthday, the claim is acceptable. At least 30 days but not more than 180 days, excluding the consent and surgery dates, must have passed between the date of the written informed consent and the date of sterilization, except in the case of premature delivery. Corrections to this field must be initialed by the recipient. (A correction does ***not*** require a new 30-day waiting period.)

Element 9 — Race and Ethnic Designation (not required)

INTERPRETER'S STATEMENT

An interpreter must be provided to assist the recipient if the recipient does not understand the language used on the consent form or the language used by the person obtaining the consent.

Elements 10 to 12 — Language, Interpreter, Date
If applicable, the date the interpreter signs can be on or prior to the recipient's signature date in Element 8.

STATEMENT OF PERSON OBTAINING CONSENT

Element 13 — Name of Recipient (required)
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 14 — Procedure (required)
The information given in Element 14 must be comparable, but not necessarily identical, to Elements 2, 6, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

Elements 15 to 18 — Signature of Person Obtaining Consent, Date, Facility, Address (required)
The person obtaining the consent may be, but is not required to be, the physician performing the procedure. A facility and/or facility address must be indicated, but only one (of the provider's choice) is required. Additionally, the signature date (Element 16) can be prior to, on, or after the date the recipient signs (Element 8). Corrections to this field must be initialed by the person obtaining consent.

PHYSICIAN'S STATEMENT

Element 19 — Name of recipient (required)
The recipient's name does not need to ***exactly*** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This does ***not*** require a new 30-day waiting period.)

Element 20 — Date of sterilization (required)
The date must match the date of service (DOS) on the claim. Reimbursement is not allowed unless at least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of the sterilization. This means the DOS must be at least the 31st day after the recipient signature date and no later than the 181st day after that date. Neither the date of informed consent nor the date of surgery will be counted as part of the 30-day requirement. In cases of premature delivery, the consent form must have been signed at least 30 days prior to the expected date of delivery as identified in Element 22 and at least 72 hours must have passed before premature delivery. In cases of emergency abdominal surgery, at least 72 hours must have passed from the date the recipient gave informed consent to be sterilized. Element 22 must be completed in the case of premature delivery or emergency abdominal surgery. Corrections to this field must be initialed by the physician.

Note: Element 20 extends to the next line on the form.

Element 21 — Specify type of operation (required)
Must be comparable to Elements 2, 6, and 14 or state "same." If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient. (This correction does ***not*** require a new 30-day waiting period.)

Element 22 — Exception to 30-Day Requirement (required if less than 31 days have passed between date of signed consent and sterilization date)
The individual's expected date of delivery must be stated in the case of premature delivery. In the case of emergency abdominal surgery, the circumstances must be described. Corrections to this field must be initialed by the physician.

Element 23 — Physician Signature and Date (required)
- Alterations to this field must be initialed by the physician.
- Initials may be used in the signature for the first and/or middle name only.
- A signature stamp or computer-generated signature is not acceptable.
- The physician's signature on the consent form does not need to exactly match the ***performing*** physician's name on the claim form. It is unacceptable for the physician's signature to be completely different from the name on the claim.
- Physician's signature date must be on or after the date the sterilization was performed.
- A nurse or other individual's signature is not acceptable.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1164A (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(3)(e), Wis. Admin. Code

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from **1** (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an **2**. The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on **3** (Month Day Year).

I, **4**, hereby consent of my own free will to be sterilized by **5** (doctor) by a method called **6**. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7 Date **8**
SIGNATURE *— Recipient* *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

9
- ❑ American Indian or Alaska native
- ❑ Asian or Pacific Islander
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in **10** language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 **12**
SIGNATURE *— Interpreter* *Date Signed*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before **13** (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation **14**, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15 **16**
SIGNATURE *— Person Obtaining Consent* *Date Signed*

17
Facility

18
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon **19** (Name of individual to be sterilized) on **20** (Date of sterilization), I explained to him/her the nature of the sterilization operation **21** (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

22
- ❑ Premature delivery
- ❑ Individual's expected date of delivery: _____
- ❑ Emergency abdominal surgery:

(describe circumstances): _____

_____

23
SIGNATURE *— Physician* *Date Signed*

Appendix 9

Sterilization Informed Consent (for photocopying)

(A copy of the Sterilization Informed Consent form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1164 (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(3)(e), Wis. Admin. Code

WISCONSIN MEDICAID
STERILIZATION INFORMED CONSENT

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*doctor or clinic*) . When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an _ _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All of my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally-funded programs.

I am at least 21 years of age and was born on _____ (*Month Day Year*).

I, _____ , hereby consent of my own free will to be sterilized by _____ (*doctor*) by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare, or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature *– Recipient* *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

☐ American Indian or Alaska native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Signature *– Interpreter* *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*name of individual*) signed the consent form, I explained to him/her the nature of the sterilization operation _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature *— Person Obtaining Consent* *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of individual to be sterilized*) on _____ (*Date of sterilization*), I explained to him/her the nature of the sterilization operation _____ (*operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
☐ Individual's expected date of delivery: _____
☐ Emergency abdominal surgery:

(describe circumstances): _____

_____

_____
Signature *– Physician* *Date*

Appendix 10

Acknowledgment of Receipt of Hysterectomy Information (for photocopying)

(A copy of the Acknowledgment of Receipt of Hysterectomy Information form is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: The Acknowledgement of Receipt of Hysterectomy Information form is to be completed by a physician before performing the surgery and attached to the CMS 1500 claim form. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

Medicaid reimbursement for a hysterectomy requires both a second surgical opinion and the completion of this form or similar form with the same information. This form is not to be used for purposes of consent of sterilization. A recipient must give voluntary written consent on the federally required Sterilization Informed Consent form.

Name — Recipient
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS. The name in this element must match the name on the claim.

Address — Recipient
Enter the recipient's address. Use the EVS to obtain the address.

Recipient's Medicaid ID No.
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.

Name — Physician
Enter the performing provider's name.

Physician's Medicaid Provider No.
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.

Name — Recipient
Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.

Signatures — Recipient, Representative, and Interpreter
Recipient — The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)

Representative — The representative must sign and date this element if a representative was required for the recipient.

Interpreter — An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.

Date Signed
Enter the date the recipient signs the Acknowledgement of Receipt of Hysterectomy Information form in this element. This date must be ***on or before*** the date of service on the claim.

Continued on reverse

WISCONSIN MEDICAID

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Name — Recipient		Address — Recipient
Recipient's Medicaid ID No.	Name — Physician	Physician's Medicaid Provider No.

It has been explained to _____ that the hysterectomy to be
(Name — Recipient)

performed on her (me) will render her (me) permanently incapable of reproducing.

SIGNATURES — Recipient, Representative, and Interpreter

Recipient

Representative

Interpreter

Date Signed

Appendix 11
Breast Pump Order (for photocopying)

(A copy of the Breast Pump Order form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1153 (Rev. 09/02)

WISCONSIN MEDICAID
BREAST PUMP ORDER

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information shall include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: The form is to be completed by the physician, given to the provider of the breast pump, and kept in the recipient's medical file as required under HFS 106.02(9), Wis. Admin. Code. The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

	1. Date of Order
2. Name — Recipient (Mother)	3. Address — Recipient
4. Date of Birth — Infant	5. Recipient's Medicaid Identification Number

6. Clinical Guidelines

All of the following must apply as a condition for Medicaid coverage. By checking the boxes, the physician verifies that all conditions are met.

- ❑ a. Physician ordered or recommended breast milk for infant.
- ❑ b. Potential exists for adequate milk production.
- ❑ c. Recipient plans to breast-feed long term.
- ❑ d. Recipient is capable of being trained to use the breast pump.
- ❑ e. Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breast-feeding difficult or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

7. Type of Pump

Physician orders or recommends the following breast pump:

- ❑ a. Breast pump, manual, any type.
- ❑ b. Breast pump, electric (AC and/or DC), any type.
- ❑ c. Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies transformer, electric (AC and/or DC).

8. Name — Physician (Type or Print)	9. Address — Physician
10. SIGNATURE — Physician	11. Date Signed

Appendix 12

Physician Services Requiring Prior Authorization

General Instructions

The list of procedures requiring prior authorization (PA) is subject to change and is periodically updated by Wisconsin Medicaid. Providers will be informed about the changes in a timely manner. General services requiring PA include the following:

- All covered physician services if provided out-of-state under nonemergency circumstances by a provider who does not have border-status certification with Wisconsin Medicaid.
- Surgical or other medical procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

Specific physician services that require PA are listed in this appendix. Contact a Medicaid-certified pharmacist or Provider Services at (800) 947-9627 or (608) 221-9883 for information regarding possible PA or diagnosis restrictions for a particular drug.

Special Circumstances

Audiological Testing for Hearing Instruments

A Prior Authorization Request Form Physician Otological Report (PA/POR) is required for audiological testing for specifications of a hearing instrument. A photocopy of the approved hearing instrument PA request form is sent to the recipient who presents it to the Medicaid-certified audiologist or hearing instrument specialist of his or her choice.

Dermabrasion

Prior authorization requests for dermabrasion (procedure codes 15780-15783) will not be approved if the purpose is tattoo removal.

Plagiocephaly — Occipital Plagiocephaly Cranial Banding (Infant Head Molding Bands)

Prior authorization requests for infant head molding bands (procedure code W6020) to correct congenital skull deformities in infants require photographic and medical record documentation. The procedure may be performed only on infants under 18 months of age. Wisconsin Medicaid approves PA requests submitted for only neurosurgeons and plastic surgeons.

Infertility and Impotence Services

Treatment of infertility and impotence are noncovered services under Wisconsin Medicaid. Drugs whose primary use is treatment of infertility or impotence may be approved through PA only when used for treatment of conditions other than infertility or impotence.

Gastroplasty

Gastroplasty for treatment of morbid obesity is allowed only in limited circumstances. An example is sleep apnea.

Organ Transplants

The hospital, rather than the physician, is responsible for obtaining PA for these services. Physicians should make sure all necessary approvals have been obtained by the hospital before proceeding with a transplant operation. Wisconsin Medicaid does not require PA for collection of the donor organ.

Appendix 12
(Continued)

Penile Prosthesis

Insertion or replacement of semirigid penile prosthesis (procedure codes 54400, 54416, and 54417) may be approved through PA only when the prosthesis is employed for purposes other than treatment of impotence (e.g., to support a penile catheter). Replacement of an inflatable penile prosthesis is not a covered service under Wisconsin Medicaid.

Vaginal Construction

Vaginal construction (procedure codes 57291 and 57292) may be approved through PA only when performed on a female (e.g., correction of a congenital defect). It will not be approved as part of a transsexual surgery.

Weight Alteration Services

All medical services (beyond five evaluation and management office visits per calendar year) aimed specifically at weight alteration and procedures to reverse such services require PA.

Procedure Codes Requiring Prior Authorization

The following procedure codes, when provided with the indicated type of service (TOS) require PA from Wisconsin Medicaid. The list of procedures requiring PA is subject to change and is periodically updated by Wisconsin Medicaid. Physicians will be informed about the changes in a timely manner.

Category	Proc. Code	TOS	Description
Drugs Administered Other Than Oral	J0256	1	Injection, alpha 1 — proteinase inhibitor — human, 10 mg
	J0270	1	Injection, alprostadil, per 1.25 mcg
	J0725	1	Injection, chorionic gonadotropin, per 1,000 USP units
	J2760	1	Injection, phentolamine mesylate (Regitine), up to 5 mg
	J3490	1	Unclassified drugs (fertility drugs require PA)
Injections	Q2014	1	Injection, sermorelin acetate, 0.5 mg
Private Payer Codes	S2053	2	Transplantation of small intestine and liver allografts
	S2054	2	Transplantation of multivisceral organs
	S2055	2	Harvesting of donor multivisceral organs, with preparation and maintenance of allografts; from cadaver donor
Integumentary System	11950	2	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
	11951	2	1.1 to 5.0 cc
	11952	2	5.1 to 10.0 cc
	11954	2	over 10.0 cc
	11960	2	Insertion of tissue expander(s) for other than breast, including subsequent expansion
	11970	2	Replacement of tissue expander with permanent prosthesis
	15780	2	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	2	segmental, face

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Integumentary System (Continued)	15782	2	regional, other than face
	15783	2	superficial, any site
	15820	2	Blepharoplasty, lower eyelid;
	15821	2	with extensive herniated fat pad
	15822	2	Blepharoplasty, upper eyelid;
	15823	2	with excessive skin weighting down lid
	15824	2	Rhytidectomy, forehead
	15825	2	neck with platysmal tightening (platysmal flap, P-flap)
	15826	2	glabellar frown lines
	15828	2	cheek, chin, and neck
	15829	2	superficial musculoaponeurotic system (SMAS) flap
	15831	2	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)
	15832	2	thigh
	15833	2	leg
	15834	2	hip
	15835	2	buttock
	15836	2	arm
	15837	2	forearm or hand
	15838	2	submental fat pad
	15839	2	other area
	19140	2	Mastectomy for gynecomastia
	19316	2	Mastopexy
	19318	2	Reduction mammaplasty
	19324	2	Mammaplasty, augmentation; without prosthetic implant
	19325	2	with prosthetic implant
	19340	2	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19342	2	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
	19350	2	Nipple/areola reconstruction
	19357	2	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
	19361	2	Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant
	19364	2	Breast reconstruction with free flap
	19366	2	Breast reconstruction with other technique
	19367	2	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;
	19368	2	with microvascular anastomosis (supercharging)
	19369	2	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site
	19380	2	Revision of reconstructed breast
	19396	2	Preparation of moulage for custom breast implant

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Musculoskeletal System	21010	2	Arthrotomy, temporomandibular joint
	21050	2	Condylectomy, temporomandibular joint (separate procedure)
	21060	2	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)
	21070	2	Coronoidectomy (separate procedure)
	21079	2	Impression and custom preparation; interim obturator prosthesis
	21080	2	definitive obturator prosthesis
	21081	2	mandibular resection prosthesis
	21082	2	palatal augmentation prosthesis
	21083	2	palatal lift prosthesis
	21084	2	speech aid prosthesis
	21085	2	oral surgical splint
	21086	2	auricular prosthesis
	21087	2	nasal prosthesis
	21088	2	facial prosthesis
	21089	2	Unlisted maxillofacial prosthetic procedure
	21120	2	Genioplasty; augmentation (autograft, allograft, prosthetic material)
	21121	2	sliding osteotomy, single piece
	21122	2	sliding osteotomies, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
	21123	2	sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
	21125	2	Augmentation, mandibular body or angle; prosthetic material
	21127	2	with bone graft, onlay or interpositional (includes obtaining autograft)
	21137	2	Reduction forehead; contouring only
	21138	2	contouring and application of prosthetic material or bone graft (includes obtaining autograft)
	21139	2	contouring and setback of anterior frontal sinus wall
	21141	2	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft
	21142	2	two pieces, segment movement in any direction, without bone graft
	21143	2	three or more pieces, segment movement in any direction without bone graft
	21145	2	single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
	21146	2	two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
	21147	2	three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)
	21150	2	Reconstruction midface, LeFort II; anterior intrusion (eg, Treacher-Collins Syndrome)
	21151	2	any direction, requiring bone grafts (includes obtaining autografts)

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Musculoskeletal System (Continued)	21154	2	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autographs); without LeFort I
	21155	2	with LeFort I
	21159	2	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
	21160	2	with LeFort I
	21172	2	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
	21175	2	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
	21179	2	with grafts (allograft or prosthetic material)
	21180	2	with autograft (includes obtaining grafts)
	21181	2	Reconstruction by contouring of benign tumor of cranial bones (eg, fibrous dysplasia), extracranial
	21182	2	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
	21183	2	total area of bone grafting greater than 40 sq cm but less than 80 sq cm
	21184	2	total area of bone grafting greater than 80 sq cm
	21188	2	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
	21193	2	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
	21194	2	with bone graft (includes obtaining graft)
	21195	2	Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation
	21196	2	with internal rigid fixation
	21198	2	Osteotomy, mandible, segmental
	21206	2	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)
	21208	2	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
	21209	2	reduction
	21210	2	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
	21215	2	mandible (includes obtaining graft)
	21230	2	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
	21235	2	ear cartilage, autogenous, to nose or ear (includes obtaining graft)
	21240	2	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)
	21242	2	Arthroplasty, temporomandibular joint, with allograft

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Musculoskeletal System (Continued)	21243	2	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
	21244	2	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)
	21245	2	Reconstruction of mandible or maxilla, subperiosteal implant; partial
	21246	2	complete
	21247	2	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)
	21248	2	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial
	21249	2	complete
	21255	2	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
	21256	2	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (eg, micro-ophthalmia)
	21260	2	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
	21261	2	combined intra- and extracranial approach
	21263	2	with forehead advancement
	21267	2	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
	21268	2	combined intra- and extracranial approach
	21270	2	Malar augmentation, prosthetic material
	21275	2	Secondary revision of orbitocraniofacial reconstruction
	21280	2	Medial canthopexy (separate procedure)
	21282	2	Lateral canthopexy
	21295	2	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy); extraoral approach
	21296	2	intraoral approach
	21299	2	Unlisted craniofacial and maxillofacial procedure
	21740	2	Reconstructive repair of pectus excavatum or carinatum
	W6020	2	Plagiocephaly — Occipital Plagiocephaly Cranial Banding (Infant Head Molding Bands)
Respiratory System	30120	2	Excision or surgical planing of skin of nose for rhinophyma
	30400	2	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	2	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	2	including major septal repair
	30430	2	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	2	intermediate revision (bony work with osteotomies)
	30450	2	major revision (nasal tip work and osteotomies)
	32851	2	Lung transplant, single; without cardiopulmonary bypass (hospital obtains PA, ***not*** physician)

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Respiratory System (Continued)	32852	2	with cardiopulmonary bypass (hospital obtains PA, ***not*** physician
	32853	2	Lung transplant, double (bilateral sequential or en bloc); without cardiopulmonary bypass (hospital obtains PA, ***not*** physician)
	32854	2	with cardiopulmonary bypass (hospital obtains PA, ***not*** physician)
Cardiovascular System	33935	2	Heart-lung transplant with recipient cardiectomy-pneumonectomy(hospital obtains PA, ***not*** physician)
	33945	2	Heart transplant, with or without recipient cardiectomy (hospital obtains PA, ***not*** physician)
	36520	2	Therapeutic apheresis; plasma and/or cell exchange
	37650	2	Ligation of femoral vein
Hemic and Lymphatic System	38240	2	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic (hospital obtains PA, ***not*** physician)
	38241	2	autologous (hospital obtains PA, ***not*** physician)
Digestive System	42145	2	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)
	42950	2	Pharyngolplasty (plastic or reconstructive operation on pharynx)
	43842	2	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
	43843	2	other than vertical-banded gastroplasty
	43846	2	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (less than 100 cm) Roux-en-Y gastroenterostomy
	43847	2	with small intestine reconstruction to limit absorption
	43848	2	Revision of gastric restrictive procedure for morbid obesity (separate procedure)
	44135	2	Intestinal allotransplantation; from cadaver donor
	44136	2	from living donor
	47135	2	Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age (hospital obtains PA, ***not*** physician)
	47136	2	heterotopic, partial or whole, from cadaver or living donor, any age (hospital obtains PA, ***not*** physician)
	47399	2	Unlisted procedure, liver (PA required only for liver-small intestine transplant)
	48160	2	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic cells (hospital obtains PA, ***not*** physician)
	48554	2	Transplantation of pancreatic allograft (hospital obtains PA, ***not*** physician)
Male Genital System	54400	2	Insertion of penile prosthesis; non-inflatable (semi-rigid)
	54416	2	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
	54417	2	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

Appendix 12
(Continued)

Category	Proc. Code	TOS	Description
Female Genital System	57291	2	Construction of artificial vagina; without graft
	57292	2	with graft
	58400	2	Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
	58410	2	with presacral sympathectomy
Nervous System	61490	2	Craniotomy for lobotomy, including cingulotomy
	61885	2	Incision and subcutaneous placement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array
	64573	2	Incision for implantation of neurostimulator electrodes; cranial nerve
Eye and Ocular Adnexa	67900	2	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
	67901	2	Repair of blepharoptosis; frontalis muscle technique with suture or other material
	67902	2	frontalis muscle technique with fascial sling (includes obtaining fascia)
	67903	2	(tarso) levator resection or advancement, internal approach
	67904	2	(tarso) levator resection or advancement, external approach
	67906	2	superior rectus technique with fascial sling (includes obtaining fascia)
	67908	2	conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
	67909	2	Reduction of overcorrection of ptosis
Auditory System	69714	2	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
	69715	2	with mastoidectomy
	69717	2	Replacement (including removal of existing device), osseointegrated implant,
	69718	2	temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy with mastoidectomy
	69930	2	Cochlear device implantation, with or without mastoidectomy
Special Otorhinolaryngologic Services	92510	1	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming
	92599	1	Unlisted otorhinolaryngological service or procedure

Appendix 13

Prior Authorization Request Form (PA/RF) Completion Instructions

The Prior Authorization Request Form (PA/RF) functions as a cover sheet and asks for general information regarding the provider, the recipient, and the service(s) for which PA is being requested. Carefully complete the PA/RF and appropriate attachments, and submit to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers also have the option of submitting PA requests by fax at (608) 221-8616. Refer to Appendix 22 of this section for more information about faxing PA requests. Providers may get their questions answered about completing PA requests by calling Provider Services at (800) 947-9627 or (608) 221-9883. Order copies of the PA/RF by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Element 1 — Processing Type

Enter the three-digit processing type "117" (physician services, including family planning clinic and rural health clinic). The "processing type" is a three-digit code used to identify a category of service requested. *Use 999 — "Other" only if the requested category of service is not considered within the category of physician services.*

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955).

Element 6 — Sex

Enter an "X" to specify male or female.

Element 7 — Billing Provider Name, Address, ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

Appendix 13
(Continued)

Element 8 — Billing Provider Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.
Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code
Enter the appropriate *Current Procedural Terminology*, Health Care Procedure Coding System, formerly HCFA Common Procedure Coding System, or local procedure code for each service/procedure/item requested.

Element 15 — MOD
Enter the two-digit modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested. When requesting PA for a bilateral procedure, indicate the "50" modifier in this element.

Element 16 — POS
Enter the appropriate Medicaid single-digit place of service (POS) code designating where the requested service/procedure/item would be provided/performed. Refer to Appendix 2 of this section for a list of POS codes and their descriptions.

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service (TOS) code for each service/procedure requested. Refer to Appendix 1 of this section for a list of Medicaid procedure codes and their allowable TOS codes. Refer to Appendix 2 of this section for a list of TOS codes and their descriptions.

Element 18 — Description of Service
Enter a written description corresponding to the appropriate three-digit revenue code, five-digit procedure code, or 11-digit National Drug Code for each service/procedure/item requested.

Element 19 — QR
Enter the quantity (e.g., number of services, dollar amount) for each service/procedure/item requested.

Appendix 13
(Continued)

Element 20 — Charges

Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

Note: The charges indicated on the PA/RF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Services *Terms of Provider Reimbursement.*

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider. This space is reserved for Wisconsin Medicaid consultants and analysts.

Appendix 14

Sample Prior Authorization Request Form (PA/RF)

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
117

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YY

6 SEX
M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
11223344

10 DX: PRIMARY
611.9 Unspecified breast disorder

11 DX: SECONDARY
724.5 Backache, unspecified

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
19318	50	1	2	Reduction Mammoplasty	1	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY
DATE

24 I.M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

482-120

Appendix 15

Prior Authorization Physician Attachment (PA/PA) Completion Instructions

(A copy of the Prior Authorization Physician Attachment (PA/PA) Completion Instructions is located on the following page.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) COMPLETION INSTRUCTIONS

Complete the Prior Authorization Physician Attachment (PA/PA), including the Prior Authorization Request Form (PA/RF), and submit it by fax to (608) 221-8616. Providers also have the option of submitting PA requests by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers with questions about completing PA requests should call Provider Services at (800) 947-9627 or (608) 221-9883.

To obtain copies of PA forms, providers have the following options:

- Refer to the forms area of the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* to download the file and print it.
- Photocopy the attachment.
- Order copies by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

  Wisconsin Medicaid
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 3 — Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the provider who would perform/provide the requested service/procedure.

Element 5 — Performing Provider's Medicaid Number
Enter the eight-digit Medicaid provider number of the physician performing the service.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including area code, of the provider performing the service.

Element 7 — Name — Ordering / Prescribing Physician
Enter the name of the referring/prescribing physician in this element.

SECTION III — SERVICE INFORMATION

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete Elements A through C.
2. Read Element 22 of the PA/RF before signing and dating the PA/PA.
3. Sign and date the PA/PA (Element D).

Appendix 16

Sample Prior Authorization Physician Attachment (PA/PA)

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11016 (Rev. 01/03)

STATE OF WISCONSIN
HFS 107.06(2), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Physician Services Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth (MM/DD/YYYY)
Recipient, Ima A.	**02/03/1955**

3. Wisconsin Medicaid Identification Number

1234567890

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

I.M. Performing

5. Performing Provider's Medicaid Number

12345678

6. Telephone Number — Performing Provider

(XXX) XXX-XXXX

7. Name — Ordering / Prescribing Physician

I.M. Referring/Prescribing

Continued on reverse

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

Bilateral mammary hyperplasia.

B. Describe medical history pertinent to service or procedure requested.

Has constant infection and weeping under the mammary fold.

C. Supply justification for service or procedure requested.

The breast structures are quite heavy and pendulous.

In excess of 500 grams will be removed from each breast.

D. SIGNATURE — Physician	Date Signed
I.M. Provider	**MM/DD/YYYY**

Appendix 17

Prior Authorization Physician Attachment (PA/PA) (for photocopying)

(A copy of the Prior Authorization Physician Attachment [PA/PA] is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Physician Services Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization Physician Attachment (PA/PA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth (MM/DD/YYYY)

3. Wisconsin Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider

5. Performing Provider's Medicaid Number

6. Telephone Number — Performing Provider

7. Name — Ordering / Prescribing Physician

Continued on reverse

SECTION III — SERVICE INFORMATION

A. Describe diagnosis and clinical condition pertinent to service or procedure requested.

B. Describe medical history pertinent to service or procedure requested.

C. Supply justification for service or procedure requested.

D. SIGNATURE — Physician	Date Signed

Appendix 18

Prior Authorization "J" Code Attachment (PA/JCA) Completion Instructions

Carefully complete the Prior Authorization "J" Code Attachment (PA/JCA), attach it to the Prior Authorization Request Form (PA/RF), and submit it to the following address:

Wisconsin Medicaid
Prior Authorization
Suite 88
6406 Bridge Rd
Madison WI 53784-0088

Providers also have the option of submitting PA requests by fax at (608) 221-8616. Refer to Appendix 22 of this section for more information about faxing PA requests. Providers may get their questions answered about completing PA requests by calling Provider Services at (800) 947-9627 or (608) 221-9883. Providers may order copies of the PA/JCA by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Recipient Information:

Element 1 — Last Name

Enter the recipient's last name. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — First Name

Enter the recipient's first name. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — M.I.

Enter the recipient's middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 5 — Age

Enter the recipient's age in numerical form (e.g., 45, 60, 21).

Section A — Drug Order Information

Complete all of Section A.

Section B — Clinical Information

Include diagnostic information, as well as clinical information, explaining the need for the drug requested.

Use:

Any of the compendium standards may be used. If an intended use is not in the drug package insert, providers may want to check the United States Pharmacopeia Drug Information (USP-DI) for the most inclusive reference for diagnosis.

If a drug use is not listed in compendium standards, it may still be covered. Therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Dose:

Any of the compendium standards may be used. If a prescribed dosage is not in the drug package insert, you may want to check the USP-DI (the most inclusive reference for diagnosis).

If a drug dosage is not listed in compendium standards, it may still be covered. Therefore, the PA/JCA must be submitted for processing and denied before the recipient is told a particular drug is not covered by Wisconsin Medicaid.

Signature of Prescriber

The prescriber must review the information and sign the PA/JCA, verifying that the information is accurate to the best of his or her knowledge.

Check the appropriate box indicating how the provider would like to be notified of an approved or denied PA request. Please be sure to indicate a fax or telephone number if selecting either of these options.

Appendix 19

Prior Authorization "J" Code Attachment (PA/JCA) (for photocopying)

(A copy of the Prior Authorization "J" Code Attachment [PA/JCA] is located on the following page.)

Mail completed forms to:
Wisconsin Medicaid
PA Unit
6406 Bridge Rd
Madison WI 53784-0088

PA/JCA

Prior Authorization

"J" Code Attachment

1. Complete the PA/JCA
2. Attach to the Prior Authorization Request Form (PA/RF)
3. Mail to Wisconsin Medicaid

Recipient Information

①	②	③	④	⑤
Last Name	First Name	M.I.	Identification Number	Age

Section A - Drug Order Information

Drug Name_____ Strength_____

National Drug Code (NDC)_____ HCPCS "J" Code_____

Quantity Ordered_____ Date order issued_____

Daily Dose_____

Prescriber Name_____ DEA Number_____

"Brand Medically Necessary": ❑Yes ❑ No

Section B - Clinical Information *(Attach* another sheet if additional room is needed.)

List the recipient's condition the prescribed drug is intended to treat. Include ICD-9-CM diagnosis codes and the expected length of need.

_____

_____

_____

If requesting a renewal or continuation of a previous prior authorization approval, indicate any changes to the clinical condition, progress, or known results to-date.

_____

_____

Use **(check one)**

❑ Compendium standards, such as the USP-DI or drug package insert, lists the intended use identified above as an accepted or as a [bracketed] indication.

❑ The intended use identified above is *not* listed in compendium standards. Peer reviewed clinical literature is attached.

Dose **(check one)**

❑ The daily dose and duration are within compendium standards general prescribing or dosing limits for the indicated use.

❑ The daily dose and duration are *not* within compendium standards general prescribing or dosing limits for the intended use. Attach peer reviewed literature which indicates this dose is appropriate or document the medical necessity of this dosing difference.

Signature_____ Date_____

The prescriber must review the information and sign and date this form.

Check the appropriate box:

Please notify me of approval/denial by: ❑Fax #_____ ❑Telephone #_____ ❑No special notice needed

Appendix 20

Prior Authorization Request Form Physician Otological Report (PA/POR) Completion Instructions

The Prior Authorization Request Form Physician Otological Report (PA/POR) is required by Wisconsin Medicaid when a hearing instrument specialist requires PA for a hearing instrument. Audiologists may use the PA/POR in place of a physician prescription, which is to be kept in the recipient's medical record. Upon completion, give one copy to the recipient to take to the testing center and retain a second copy for your files. Providers may order carbon paper copies of the PA/POR by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

For more information about completing PA requests, providers may call Provider Services at (800) 947-9627 or (608) 221-9883.

Element 1 — Physician Name, Address (Street, City, State, ZIP Code)

Enter the name and address, including ZIP code, of the requesting physician.

Element 2 — Evaluation Date

Enter the date the recipient was examined in MM/DD/YYYY format.

Element 3 — Physician's Signature and Date

The requesting physician must sign the form and enter the date the request is made.

Element 4 — Physician's UPIN, Medicaid, or License Number

Enter the eight-digit Medicaid provider number, six-digit Medicare Universal Provider Identification Number, or license number of the physician.

Element 5 — Physician's Telephone Number

Enter the telephone number, including area code, of the requesting physician.

Element 6 — Recipient's Medicaid ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 7 — Sex

Enter an 'X' in the appropriate box.

Element 8 — Recipient Address (Street, City, State, ZIP Code)

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 9 — Recipient's Name (Last, First, M.I.) as on Medicaid ID Card

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 10 — Date of Birth
Enter the recipient's date of birth in MM/DD/YYYY format.

Element 11 — Medical History of Hearing Loss
Enter the recipient's medical history of hearing loss (if any).

Element 12 — Pertinent Otological Findings
Enter an 'X' in the appropriate box(es) and describe all problems.

Element 13 — Additional Findings
Describe any additional findings not covered in Element 11.

Element 14 — Clinical Diagnosis of Hearing Status
Enter the diagnosis of the recipient's hearing status.

Element 15 — Medical, Cognitive, or Developmental Problems
Describe any medical cognitive or developmental problems of the recipient.

Element 16 — Physician's Recommendations
Enter an 'X' in the appropriate box(es) to indicate the physician's recommendations.

Appendix 21

Prior Authorization Request Form Physician Otological Report (PA/POR) (for photocopying)

(A copy of the Prior Authorization Request Form Physician Otological Report [PA/POR] is located on the following page.)

PRIOR AUTHORIZATION REQUEST FORM
PHYSICIAN OTOLOGICAL REPORT

This form is required by Wisconsin Medicaid when a hearing instrument specialist requires prior authorization for a hearing instrument.

- COMPLETE EACH ITEM ON FORM.
- GIVE FIRST PAGE TO THE RECIPIENT TO TAKE TO THE TESTING CENTER.
- RETAIN SECOND PAGE FOR YOUR FILES.

1 PHYSICIAN NAME, ADDRESS (STREET, CITY, STATE, ZIP CODE)

2 EVALUATION DATE _____ MM/DD/YYYY

3 PHYSICIAN'S SIGNATURE AND DATE _____ M.D. SIGNATURE _____ MM/DD/YYYY

4 PHYSICIAN'S UPIN, MEDICAID, OR LICENSE NUMBER

5 PHYSICIAN'S TELEPHONE NUMBER ( )

6 RECIPIENT'S MEDICAID ID NUMBER — — — — — — — — — —

7 SEX M ☐ F ☐

8 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

9 RECIPIENT'S NAME (LAST, FIRST, M.I.) AS ON MEDICAID ID CARD

10 DATE OF BIRTH

11 MEDICAL HISTORY OF HEARING LOSS

12 PERTINENT OTOLOGICAL FINDINGS

		NORMAL (Check below)	PROBLEMS (Describe)
RIGHT	Canal	[ ]	_____
	Ear Drum	[ ]	_____
	Middle Ear	[ ]	_____
LEFT	Canal	[ ]	_____
	Ear Drum	[ ]	_____
	Middle Ear	[ ]	_____

13 ADDITIONAL FINDINGS
e.g. results of special studies, such as caloric and postural tests (describe):

14 CLINICAL DIAGNOSIS OF HEARING STATUS

15 MEDICAL, COGNITIVE, OR DEVELOPMENTAL PROBLEMS

16 PHYSICIAN'S RECOMMENDATIONS (Check all applicable)

[ ] I have medically evaluated this patient and refer him/her for a hearing instrument evaluation as follows:

[ ] One or more of the situations listed below applies to this patient. Therefore, as required by Medicaid regulations, I refer this patient to an audiologist for a hearing instrument evaluation/diagnosis:

[ ] The patient is 21 years of age or under.
[ ] The patient is behaviorally or cognitively impaired.
[ ] The patient has other special needs requiring a comprehensive evaluation or specialized diagnostic tools of a clinically certified evaluation.

[ ] None of the above situations applies to this patient. Either an audiologist or a hearing instrument specialist may provide the hearing instrument evaluation.

[ ] A home hearing test may be required.

Appendix 22

Prior Authorization Fax Procedures

Providers may fax prior authorization (PA) requests to Wisconsin Medicaid at (608) 221-8616. Prior authorization requests sent to any Wisconsin Medicaid fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to Wisconsin Medicaid, providers should follow the guidelines/procedures listed below:

Include a Fax Transmittal Cover Letter

Include a completed fax transmittal cover letter that includes the following:

- Date of the fax transmission.
- Number of pages including the cover sheet. The Medicaid fax clerk will contact the provider by fax or telephone if all the pages do not transmit. (Refer to the "Incomplete Fax Transmissions" section of this appendix for instructions if all the pages do not transmit.)
- Provider contact person and telephone number. The Wisconsin Medicaid fax clerk may contact the provider with any questions about the fax transmission.
- Wisconsin Medicaid provider identification number.
- Fax telephone number to which Wisconsin Medicaid may send its adjudication decision.
- To: "Wisconsin Medicaid Prior Authorization."
- Wisconsin Medicaid's fax telephone number ([608] 221-8616). Prior authorization requests sent to any other Wisconsin Medicaid fax number may result in processing delays.
- Wisconsin Medicaid's telephone numbers. For specific PA questions, providers should call (800) 947-9627 or (608) 221-9883. For faxing questions, providers should call (608) 221-4746, extension 3064.

Incomplete Fax Transmissions

If all the pages listed on the initial cover sheet do not transmit (i.e., pages have stuck together, the fax machine has jammed, or some other error has stopped the fax transmission) or if the PA request is missing information, providers will receive the following by fax from the Medicaid fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that Medicaid received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the *entire* original fax transmission *and* the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to Wisconsin Medicaid, providers should not reduce the size of the Prior Authorization Request Form (PA/RF) to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, Wisconsin Medicaid will mail the decision back to the provider.

Wisconsin Medicaid will attempt to fax the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call Medicaid's fax clerk at (608) 221-4746, extension 3064, to check the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has *not* changed. All actions regarding PA requests are made within the time frames outlined in the Prior Authorization section of the All-Provider Handbook.

Faxed PA requests must be received by 1:00 p.m., otherwise they will be considered as received the following business day. Faxed PA requests received on Saturday or Sunday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will create duplicate PA requests and may result in delays.

Submitting New Prior Authorization Requests

Providers should not photocopy and reuse the same PA/RF for other requests. When submitting a *new* request for PA, it must be submitted on a new PA/RF so that the request is processed under a new PA number. This requirement applies whether the PA request is submitted by fax or by mail.

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments, which includes Wisconsin Medicaid's 15-digit internal control number located on the top half of the PA/RF. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive eligibility). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

For More Information

Refer to the Prior Authorization section of the All-Provider Handbook for information on responses to PA requests and how to amend them.

Appendix 23

Second Surgical Opinion Requirement

The requirement for a second opinion was created to help recipients make informed decisions about certain elective surgical procedures. Second opinions can be performed by any Wisconsin Medicaid-certified physician willing to provide them. For a list of Medicaid-certified physicians who perform second opinions, call Provider Services at (800) 947-9627 or (608) 221-9883.

All Medicaid recipients, with the exception of recipients enrolled in a Medicaid HMO or in emergent, urgent, or waiver situations are required to undergo a second surgical opinion before having one of the surgical procedures listed in Appendix 24 of this section on an elective basis. Refer to Appendix 25 of this section for the emergent, urgent, and waiver situations. Refer to Appendix 26 of this section for a copy of the Second Opinion Elective Surgery Request/Physician Report form.

The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

How to Obtain a Second Opinion

The following is a list of steps for obtaining a second opinion:

1. When one of the surgical procedures which requires a second opinion is recommended, the recommending surgeon explains to the recipient that a second opinion is required. Refer to Appendix 24 of this section for a list of procedures that require a second opinion.

2. The recommending surgeon completes the first page of the Second Opinion Elective Surgery Request/Physician Report form. Refer to Appendix 26 of this section for a blank form for photocopying.

3. The recipient is then referred to another physician for the second opinion evaluation. The recommending surgeon provides the names of any two Medicaid-certified physicians from whom the recipient can choose.

   If the recipient wants a different physician than the two recommended, have him or her call Recipient Services at (800) 362-3002 or (608) 221-5720 for a list of other physicians in his or her area who provide second opinions.

4. The recommending surgeon forwards the Second Opinion Elective Surgery Request/Physician Report form and any laboratory results, X-rays, or recipient histories that will help the second opinion physician.

   Note: The recommending surgeon must inform the second opinion physician whether to send the completed Second Opinion Elective Surgery Request/Physician Report form back to the recommending surgeon or to the address indicated on the back of the form.

5. The second opinion physician evaluates the recipient to determine the appropriateness of the recommended surgery. The second opinion physician may contact the recipient's physician for clarification or additional information.

6. The second opinion physician completes the second page of the Second Opinion Elective Surgery Request/Physician Report form and discusses his or her opinion regarding the recommended surgery with the recipient.

Appendix 23
(Continued)

7. The second opinion physician then sends the Second Opinion Elective Surgery Request/Physician Report form directly to the recommending surgeon *or* to Wisconsin Medicaid (at the address on the form), depending on what the recommending surgeon requested on the form. In the absence of any request from the recommending surgeon, the second opinion physician sends the form to Wisconsin Medicaid. Wisconsin Medicaid will make a copy of the form and send it to the recommending surgeon so surgery may be scheduled if the recipient so chooses.

   Note: Wisconsin Medicaid will not reimburse the second opinion physician if he or she chooses to perform the surgery.

8. The proposing surgeon may then perform the procedure whether the second opinion physician agreed with the need for surgery or not. Claims are not payable if the surgery date of service (DOS) is before the second opinion DOS. If the surgery is not performed within six months of the second opinion examination, a new second opinion is required (except for cataract and joint replacement surgery second opinions, which are valid indefinitely).

9. The recommending surgeon must document that a second opinion evaluation occurred. The documentation need not be in the recipient's medical records, but must be retrievable by the surgeon's office.

Duplication of Diagnostic Services

Diagnostic information pertinent to the proposed surgery should be sent by the recommending surgeon to the second opinion physician to avoid duplication of diagnostic services and costs.

Recommending Surgeon Billing Options

Recommending surgeons have two billing alternatives, depending on where the physician requests the completed Second Opinion Elective Surgery Request/Physician Report form be sent (e.g., back to the recommending surgeon or to Wisconsin Medicaid). Please refer to billing instructions.

Option 1:

If the second opinion physician sends the completed Second Opinion Elective Surgery Request/Physician Report form back to the recommending surgeon, the recommending surgeon may then perform the surgery and must include *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code **V67.S** when billing for the surgery. The recommending physician must document, in a retrievable file, that a second opinion evaluation occurred.

Option 2:

If the second opinion physician sends the completed Second Opinion Elective Surgery Request/Physician Report form to Wisconsin Medicaid, the recommending surgeon will receive a copy of the form from Wisconsin Medicaid. The surgeon then may perform the surgery and bill the appropriate surgical procedure code. (Diagnosis code V67.S does not have to be included on the claim in this case.) The recommending physician must document, in a retrievable file, that a second opinion evaluation occurred.

Second Opinion Physician Billing

The second opinion physician bills for the second opinion evaluation using ICD-9-CM diagnosis code V67.S ***and*** the appropriate evaluation and management confirmatory consultation procedure code.

Second Opinion for Dual Entitlees

Wisconsin Medicaid strongly encourages providers to obtain a second opinion for dual entitlees. A second opinion is not required if Medicare allows charges for the surgery.

Note: If Medicare denies payment or if a recipient is thought not to be dually eligible but does, in fact, have Medicare Part B coverage, Wisconsin Medicaid will deny the service if no second opinion was obtained.

Retroactive Eligibility and Second Opinion Surgeries

A second opinion is not required when a recipient is retroactively eligible for the surgery date. Physicians billing for a second opinion surgery on a retroactively eligible recipient must indicate ICD-9-CM diagnosis code V67.S and the appropriate surgical procedure code on the claim.

How Long are Second Opinions Valid?

A second opinion is valid for six months from the date of the second opinion, except for cataract extraction and joint replacement second opinions, which are valid indefinitely.

Appendix 24

Surgery Procedure Codes That Require a Second Opinion

Procedure	Procedure Code	Description
Cataract extraction	66840	Removal of lens material; aspiration technique, one or more stages
	66850	phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration
	66852	pars plana approach, with or without vitrectomy
	66920	intracapsular
	66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
	66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
	66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
Cholecystectomy	47562	Laparoscopy, surgical; cholecystectomy
	47563	cholecystectomy with cholangiography
	47600	Cholecystectomy;
	47605	with cholangiography
	47610	Cholecystectomy with exploration of common duct
D&C, diagnostic	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
Hemorrhoidectomy	46250	Hemorrhoidectomy, external, complete
	46255	Hemorrhoidectomy, internal and external, simple;
	46257	with fissurectomy
	46258	with fistulectomy, with or without fissurectomy
	46260	Hemorrhoidectomy, internal and external, complex or extensive;
	46261	with fissurectomy
	46262	with fistulectomy, with or without fissurectomy

Appendix 24
(Continued)

Procedure	Procedure Code	Description
Hernia, inguinal	49505	Repair inital inguinal hernia, age 5 years or over; reducible
	49520	Repair recurrent inguinal hernia, any age; reducible
	49525	Repair inguinal hernia, sliding, any age
Hysterectomy	58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
	58152	with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
	58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
	58260	Vaginal hysterectomy;
	58262	with removal of tube(s), and/or ovary(s)
	58263	with removal of tube(s), and/or ovary(s), with repair of enterocele
	58267	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control)
	58270	with repair of enterocele
	58275	Vaginal hysterectomy, with total or partial vaginectomy
	58550	Laparoscopy, surgical; with vaginal hysterectomy with or without removal of tube(s), with or without removal of ovary(s) (laparoscopic assisted vaginal hysterectomy)
	59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)
Joint Replacment, hip	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
Joint Replacement, knee	27445	Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
Tonsillectomy, adenoidectomy	42820	Tonsillectomy and adenoidectomy; under age 12
	42821	age 12 or over
	42825	Tonsillectomy, primary or secondary; under age 12
	42826	age 12 or over
	42830	Adenoidectomy, primary; under age 12
	42831	age 12 or over
	42835	Adenoidectomy, secondary; under age 12
	42836	age 12 or over

Appendix 24
(Continued)

Procedure	Procedure Code	Description
Varicose Vein Surgery	37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
	37720	Ligation and division and complete stripping of long or short saphenous veins
	37730	Ligation and division and complete stripping of long and short saphenous veins
	37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
	37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
	37785	Ligation, division, and/or excision of recurrent or secondary varicose veins (clusters), one leg

Appendix 25

Second Surgical Opinion Waivers

Waivers for Special Situations

Wisconsin Medicaid commonly waives the second opinion requirement when documentation supporting one of the following situations is submitted with the claim:

- Surgery, different than that which requires a second opinion, is needed and the surgery which requires a second opinion may be performed at the same operative session. Examples are cholecystectomy performed during emergency gastric surgery, or tonsillectomy/adenoidectomy when ear tubes are inserted.
- A second opinion physician is not available within a 40-mile radius of the recipient.
- The recipient is difficult to examine (e.g., combative, difficult to manage).

The Wisconsin Medicaid chief medical officer may approve waivers for nonmedical reasons other than the above. If special, nonmedical reasons exist, the recommending surgeon may send a letter describing the circumstances to the following address:

Chief Medical Officer
Division of Health Care Financing
PO Box 309
Madison WI 53701-0309

Waivers for Urgent or Emergent Conditions

If a surgery that requires a second opinion is performed under emergency or urgent conditions, a second opinion is not required. ***However***, appropriate documentation must be attached to the claim to enable Wisconsin Medicaid to determine an emergency or urgent condition existed to reimburse the claim. The best documentation is the preoperative history and physical exam report.

The following are examples of emergency or urgent clinical findings that may influence a decision to proceed with the surgery without obtaining a second opinion. This list is not all inclusive:

Cataract Extraction

- Glaucoma.
- Penetrating keratoplasty.

Cholecystectomy

- Abdominal, epigastric, or right upper-quadrant pain.
- Right upper-quadrant tenderness.
- Right upper-quadrant rebound (pain).
- Indication of stones as substantiated by X-ray or ultrasound.
- Pancreatitis with elevated amylase.
- Bilirubin over 3.8.
- Jaundice with elevated liver-function tests.
- Gallstones found at time of other intra-abdominal surgery.

Dilation and Curettage

- Heavy bleeding with clots requiring six or more pads in 24 hours for more than six days in duration.
- Postpartum bleeding within three months of delivery (should be billed as *Current Procedural Terminology* [CPT] code 59160).
- Missed (incomplete) abortion (should be billed as CPT code 59820).

- Postmenopausal bleeding (periods absent at least one year).
- Hemoglobin less than 9.5 and/or hemacrit less than 30 associated with excessive vaginal bleeding.
- Removal of intrauterine device.
- Hydatidiform mole.
- Large endocervical polyp (0.5 cm) present.
- Cancer, or suspected cancer, of the uterus, cervix, or vagina (e.g., endometrial carcinoma, cervical cancer, abnormal Pap).

Hemorrhoidectomy

- Abscess.
- Profuse (extensive) bleeding.
- Thrombosis or ulceration of vein in association with pain.
- Prolapse of hemorrhoids.

Hernia, Inguinal

- Incarceration — entrapment, confinement, or bowel obstruction.
- Scrotal hernia.
- Acute pain.
- Strangulation.

Hysterectomy

- Cancer of the uterus, endometrium, ovary, or cervix.
- Rupture of the uterus.
- Perforation of the uterus during a Dilation and Curettage.
- Severe endometriosis.
- Atypical cells class 3-4.
- Dysplasia, severe.
- Definite or suspicious cancer cells.
- Extensive vaginal bleeding and recipient is anemic.
- Symptomatic fibroids.
- Pelvic mass.
- Severe pelvic inflammatory disease (PID).

Joint Replacement

- Aseptic necrosis of the femur or hip.
- Fracture of involved hip or knee and recipient is hospitalized.

Tonsillectomy, Adenoidectomy

- Peritonsillar or retropharyngeal abscess.
- Severe obstruction inhibiting breathing.
- Size of tonsils/adenoids severely impairs breathing.
- Sleep apnea, verified by testing.

Varicose Veins

- Phlebitis present (inflammation).

Appendix 26

Second Opinion Elective Surgery Request / Physician Report (for photocopying)

(A copy of the Second Opinion Elective Surgery Request / Physician Report is located on the following pages.)

(This page was intentionally left blank.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1163 (Rev. 01/03)

WISCONSIN MEDICAID
SECOND OPINION ELECTIVE SURGERY REQUEST / PHYSICIAN REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

INSTRUCTIONS: All Medicaid recipients, with the exception of recipients enrolled in a Medicaid HMO or in emergent, urgent, or waiver situations, are required to obtain a second surgical opinion (SSO) before having one of the surgical procedures listed in the Medicine and Surgery section of the Physician Services Handbook on an elective basis.

The ultimate responsibility for the decision to undergo or forego the proposed surgery remains with the recipient. The proposed surgery is reimbursable if the recipient decides to undergo the procedure, whether the second opinion physician agrees or disagrees with the recommending surgeon.

SECTION I — RECOMMENDING SURGEON INFORMATION

Date (MM/DD/YY)

Note: The recommending surgeon must complete Section I of the form before sending the form to the second opinion physician.

Check One
- ❑ I would like the second opinion physician to send this form back to me.
- ❑ I would like the second opinion physician to send this form directly to Wisconsin Medicaid.

Recipient (Patient) Information

Name — Recipient	Wisconsin Medicaid Identification Number (10 digits)	
Address (Street / P.O. Box)		
City	State	Zip Code
Telephone Number	County	
Birth Date (MM/DD/YY)	Gender ❑ Female ❑ Male	

Recommending Surgeon (mailing address)

Name — Recommending Surgeon	Wisconsin Medicaid Provider Number (eight digits)	
Address (Street)		
City	State	Zip Code
Telephone Number		

Continued on reverse

Specify whether someone other than the recipient (parent, relative, guardian, etc.) should be contacted concerning the second opinion.

Name — Contact Person	Telephone Number

Address (Street)

City	State	Zip Code

Primary / Referring Physician (if different from above)

Name — Primary / Referring Physician

Address (Street)

City	State	Zip Code

Check Proposed Procedure

- ❑ Cataract extraction and/or intraocular lens implant (❑ check if bilateral)
- ❑ Cholecystectomy
- ❑ D&C (diagnostic)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (❑ check if bilateral)
- ❑ Hysterectomy
- ❑ Joint replacement — hip (❑ check if bilateral)
- ❑ Joint replacement — knee (❑ check if bilateral)
- ❑ Tonsillectomy and/or adenoidectomy
- ❑ Varicose vein surgery

SIGNATURE — Recommending Surgeon	Date Signed

SECTION II — SECOND OPINION PHYSICIAN INFORMATION

Note: The physician performing the second opinion must complete this section of the form.

Name — Performing Physician	Wisconsin Medicaid Provider Number (eight digits)

Address (Street)

City	State	Zip Code

Findings (include any information on alternative treatment, additional medical tests, or other significant findings)

❑ These findings and options / alternatives were presented to the recipient.

Check One
- ❑ I agree with the need for the surgery.
- ❑ I do not agree with the need for the surgery.

Comments

SIGNATURE — Second Opinion Physician	Date Signed

Distribution: Following the recommending surgeon's request indicated on the front page, return this form to either the recommending surgeon whose name and address are listed on the front page, or mail to:

Wisconsin Medicaid
SSO Dept
6406 Bridge Rd
Madison WI 53784-0012

Appendix 27

Health Personnel Shortage Area-Eligible Procedure Codes and ZIP Codes

Wisconsin Medicaid provides enhanced reimbursement to primary care providers who either provide care within areas designated by the federal Health Resources and Services Administration (HRSA) as a Health Personnel Shortage Area (HPSA) or to recipients who reside in these areas.

Health Personnel Shortage Area-Eligible Procedure Codes	
Category	**Procedure Code(s)**
Evaluation and Management Services	
New Patient	99201, 99202, 99203, 99204, 99205
Established Patient	99211, 99212, 99213, 99214, 99215
Emergency Department	99281, 99282, 99283, 99284, 99285
Preventive Medicine	94772, 96110, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99431, 99432, 99433, 99435
Obstetric Care	59020, 59025, 59050, 59300, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 76805, 76810, 76815, 76818, 76819, 76825, 76826, 76827, 76828, 76830 W6000 — Antepartum care, initial visit W6001 — Antepartum care, two to three visits
Vaccines	90701, 90702, 90704, 90705, 90706, 90707, 90708, 90709, 90712, 90744 W7020 — Hepatitis B vaccine (pediatric formulation)

Health Personnel Shortage Area Modifiers	
Modifier	**Description**
HP	HPSA/Adult (over 18 years of age)
HK	HPSA/Child (18 years of age and under)

Appendix 27
(Continued)

Health Personnel Shortage Areas

The county is listed for informational purposes only. Not all ZIP codes in a county may be included in the HPSA.

HPSA Name	County	ZIP Codes
Adams County	Adams	Entire county: 54457, 54966, 54613, 54943, 54646, 54930, 53934, 53936, 53964, 53910, 53952, 53965, 53930
Arcadia	Trempealeau	54612
	Buffalo	54747, 54612, 54622, 54629
Athens/Edgar	Marathon	54411, 54426, 54451
Baldwin	St. Croix	54002, 54737, 54012, 54013, 54015, 54027, 54767, 54022, 54023
Bayfield	Ashland	54850
	Bayfield	54814
Beloit	Rock	53511
Boscobel	Crawford	53805, 53826, 53831, 54657
	Grant	53518, 53573, 53801, 53805, 53809, 53816, 53917, 53927
Burnett County	Burnett	Entire county: 54830, 54840, 54893, 54801, 54853, 54837, 54872, 54871, 54813
Calumet County	Calumet	Entire county: 54915, 54952, 54110, 54129, 53014, 53061, 54130, 53042
Chetek/Colfax	Barron	54004, 54005, 54728, 54733, 54757, 54762, 54812, 54868, 54889
	Dunn	54725, 54730, 54734, 54749, 54751, 54763, 54765, 54772
Clark County	Clark	Entire county: 54498, 54422, 54425, 54405, 54768, 54771, 54460, 54421, 54488, 54479, 54446, 54741, 54754, 54437, 54493, 54420, 54746, 54456, 54436, 54466
Clintonville/Marion	Outagamie	54922, 54929
	Shawano	54928, 54950
	Waupaca	54950, 54929, 54922, 54170
Columbia County	Columbia	Entire county: 53555, 53901, 53911, 53923, 53925, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53965, 53969
Coon Valley/Chaseburg	LaCrosse	54623, 54619, 54667
	Vernon	54623, 54621

Appendix 27
(Continued)

HPSA Name	County	ZIP Codes
Darlington/Schullsburg	Lafayette	53565, 53530, 53504, 53516, 53587, 53541, 53586, 61001, 61075
Dodgeville/Mineral Point	Iowa	53503, 53506, 53507, 53516, 53526, 53533, 53535
		53543, 53544, 53553, 53554, 53565, 53569, 53573, 53582
Durand	Buffalo	54736, 54737
	Dunn	54736, 54737, 54751, 54755
	Pepin	54721, 54736, 54759, 54769
	Pierce	54021, 54723, 54740, 54750, 54761, 54767
Eastern Marinette/ Southern Menomonie	Marinette	54143, 54157, 54159, 54177
Elcho	Langlade	54428, 54485, 54435, 54462, 54424
	Oneida	54463, 54435
Florence	Florence	54151, 54120, 54121, 54542, 49935
Forest County	Forest	Entire county: 54562, 54511, 54551, 54516, 54103, 54520, 54541, 54125, 54465, 54104, 54138
Frederic/Luck	Polk	54840, 54006, 54853, 54837, 54829
Galesville/Trempealeau	Trempealeau	54627, 54630, 54661
Genoa	Vernon	54658, 54632, 54628, 54624
Hayward/Radisson	Bayfield	54832, 54838, 54821, 54839, 54855, 54517
	Sawyer	54821, 54517, 54843, 54876, 54817, 54828, 54867, 54835, 54862, 54896, 54526, 54530, 54555
	Washburn	54843, 54876
Hillsboro	Juneau	54634, 53968
	Monroe	54651, 54670, 54638, 53929
	Richland	54672, 53924
	Sauk	53968
	Vernon	54651, 54634, 54638, 53929, 54672, 53968
Ironwood/Hurley	Iron	54559, 54550, 54534, 54527, 54547, 54545
Kenosha	Kenosha	53140, 53142, 53143, 53144
Kewaunee City	Kewaunee	54201, 54205, 54216, 54208, 54217

Appendix 27
(Continued)

HPSA Name	County	ZIP Codes
Lancaster/Fennimore	Grant	53802, 53804, 53806, 53809, 53810, 53813, 53820, 53569
Land O'Lakes/Presque Isle	Vilas	54557, 54567, 54540
Markesan/Kingston	Green Lake	53949, 53946, 53926, 53923, 53956
Mauston/New Lisbon	Juneau	54413, 54666, 54646, 54618, 53950, 53929, 53948, 53944
Menominee County	Menominee	Entire county: 54150, 54135, 54174, 54124
Milwaukee	Milwaukee	53203, 53206, 53212, 53205, 53208, 53209, 53210, 53216, 53218, 53233, 53204, 53215
Minong/Solon Springs	Douglas	54830, 54838, 54859, 54873, 54815
	Washburn	54859, 54888
Mondovi	Buffalo	54755, 54610
	Pepin	54755
Montello	Marquette	54930, 54982, 54960, 53964, 54968, 53952, 53946
Mountain/White Lake	Langlade	54445, 54566, 54175, 54491, 54430
	Oconto	54104, 54138, 54175, 54114, 54149, 54491, 54161, 54174, 54112
Oconto/Oconto Falls	Oconto	54101, 54124, 54176, 54139, 54153, 54154, 54174
	Shawano	54127
Osseo	Eau Claire	54741, 54722, 54770, 54758
	Jackson	54741, 54758
	Trempealeau	54770, 54758
Park Falls/Phillips	Sawyer	54852
	Ashland	54527, 54514, 54852, 54517
	Iron	54552
	Price	54514, 54552, 54524, 54538, 54555, 54530, 54537, 54515, 54556
Platteville/Cuba City	Grant	53554, 53818, 53807
	Iowa	53554, 53580
	Lafayette	53510, 53818, 53807, 53803, 53811, 61075
Pulaski	Brown	54162
	Shawano	54162, 54165
	Oconto	54162

Appendix 27
(Continued)

HPSA Name	County	ZIP Codes
Sister Bay- Washington Island	Door	54246, 54210, 54234, 54211, 54202, 54212
Sparta	Monroe	54656, 54648, 54619
Spooner/Shell Lake	Washburn	54542, 54801, 54813, 54817, 54843, 54870, 54871, 54875, 54888
Spring Green/Plain	Richland	53540, 53556, 53584
	Sauk	53138, 53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951, 53961
Sturgeon Bay	Door	54209, 54235, 54202, 54201, 54213, 54217
Taylor County	Taylor	Entire county: 54766, 54490, 54470, 54433, 54451, 54768, 54771, 54447, 54498, 54460, 54422, 54425, 54480
Tigerton/Birnamwood	Marathon	54414, 54427, 54499
	Shawano	54409, 54414, 54427, 54486, 54499
	Waupaca	54486
Tomahawk	Lincoln	54501, 54564, 54487
	Oneida	54564, 54487
	Price	54513, 54459
Washburn/Bayfield	Bayfield	54806, 54814, 54827, 54847, 54856, 54865, 54891
City of Wausau	Marathon	54401, 54403
Wautoma/Plainfield/Wild Rose	Waushara	54966, 54909, 54984, 54982, 54943, 54930, 54960
Western Marinette	Marinette	54102, 54104, 54119, 54125, 54177, 54114, 54159, 54161

Appendix 28

Clozapine Management

Conditions for Coverage of Clozapine Management

Physicians and physician clinics may be separately reimbursed for clozapine management services when all of the following conditions are met:

- A physician prescribes the clozapine management services in writing if any of the components of clozapine management are provided by the physician or by individuals who are under the general supervision of a physician. Although separate prescriptions are not required for clozapine tablets and clozapine management, the clozapine management service must be identified as a separately prescribed service from the drug itself.
- The recipient is currently taking or has taken clozapine tablets within the past four weeks.
- The recipient resides in a community-based setting (excludes hospitals and nursing homes).
- The physician or qualified staff person has provided the components of clozapine management as described below.

Clozapine is appropriate for recipients with an *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code diagnosis between 295.10 and 295.95 ***and*** who have a documented history of failure with at least two psychotropic drugs. Lithium carbonate may not be one of the two failed drugs. Reasons for the failure may include:

- No improvement in functioning level.
- Continuation of positive symptoms (hallucinations or delusions).
- Severe side effects.
- Tardive dyskinesia/dystonia.

Components of Clozapine Management

The following components are part of the clozapine management service (regardless of which of the three clozapine management procedure codes is billed) and must be provided, as needed, by the physician or by a qualified professional under the general supervision of the physician:

- Ensure that the recipient has the required weekly or biweekly white blood cell count testing. Recipients must have a blood sample drawn for white blood count testing before initiation of treatment with clozapine and must have subsequent white blood counts done weekly for the first six months of clozapine therapy.

  If a recipient has been on clozapine therapy for six months of continuous treatment and if the weekly white blood counts remain stable (greater than or equal to 3,000/mm^3) during the period, the frequency of white blood count monitoring may be reduced to once every two weeks. For these recipients, further weekly white blood counts require justification of medical necessity. *Recipients who have their clozapine dispensed every week but who have a blood draw for white blood cell count every two weeks qualify for biweekly, not weekly, clozapine management services.*

  For recipients who have a break in therapy, white blood cell counts must be taken at a frequency in accordance with the rules set forth in the "black box" warning of the manufacturer's package insert.

  The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the recipient's residence, or other places in the community where the recipient is available, to perform this service, if necessary. The provider's transportation to and from the recipient's home or other community location to carry out any of the required

services listed here are considered part of the capitated weekly or biweekly payment for clozapine management and is not separately reimbursable. The blood test is separately reimbursable for a Medicaid-certified laboratory.

- Obtain the blood test results in a timely fashion.
- Ensure that abnormal blood test results are reported in a timely fashion to the provider dispensing the recipient's clozapine.
- Ensure that the recipient receives medications as scheduled and that the recipient stops taking medication when a blood test is abnormal, if this decision is made, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being is maintained.
- Make arrangements for the transition and coordination of the use of clozapine tablets and clozapine management services between different care locations.
- Monitor the recipient's mental status according to the care plan. The physician is responsible for ensuring that all individuals having direct contact with the recipient in providing clozapine management services have sufficient training and education. These individuals must be able to recognize the signs and symptoms of mental illness, the side effects from drugs used to treat mental illness, and when changes in the recipient's level of functioning need to be reported to a physician or registered nurse.
- Keep records as described below.

Record Keeping Requirements for Clozapine Management

The provider who bills for clozapine management must keep a unique record for each recipient for whom clozapine management is provided. This record may be a part of a larger record, which is also used for other services, if the provider is also providing other services to the recipient. However, the clozapine management records must be clearly identified as such, and must contain the following:

- A face sheet identifying the recipient, to include the following information:
  - ✓ Recipient's Medicaid identification number.
  - ✓ Recipient's name.
  - ✓ Recipient's current address.
  - ✓ Name, address, and telephone number of the primary medical provider (if different from the prescribing physician).
  - ✓ Name, address, and telephone number of the dispensing provider from whom the recipient is receiving clozapine tablets.
  - ✓ Address and telephone number of other locations at which the client may be receiving a blood draw on his or her own.
  - ✓ Address and telephone number where the recipient can often be contacted.
- A care plan indicating the manner in which the provider ensures that the covered services are provided (e.g., plan indicates where and when blood will be drawn, whether the recipient will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might result from side effects of the drug, or other signs or symptoms related to the recipient's mental illness, which should be reported to a qualified medical professional. The plan should indicate the health care professionals to whom oversight of the clozapine management services has been delegated and indicate how often they will be seeing the recipient. The plan should be reviewed every six months during the first year of clozapine use. Reviews may be reduced to once per year after the first year of use if the recipient is stable, as documented in the record.

- Copies of physician's prescriptions for clozapine and clozapine management.
- Copies of laboratory results of white blood cell counts.
- Signed and dated notes documenting all clozapine management services. Indicate date of all blood draws as well as who performed the blood draws. If the provider had to travel to provide services, indicate the travel time. Document services provided to ensure that the recipient received medically necessary care following an abnormal white blood cell count.

Physicians and physician clinics providing clozapine management services must be extremely careful not to double bill Wisconsin Medicaid for services. This may happen when physicians provide clozapine management services during the same encounter as when they provide other Medicaid-allowable physician services. In these cases, the physician must document the amount of time spent on the other physician service separately from the time spent on clozapine management. Regular psychiatric medication management is not considered a part of the clozapine management services; and therefore, may be billed separately.

Noncovered Clozapine Management Services

Wisconsin Medicaid does not cover the following as clozapine management services:

- Clozapine management for a recipient not receiving clozapine, except for the first four weeks after discontinuation of the drug.
- Clozapine management for recipients residing in a nursing facility or hospital on the date of service.
- Care coordination or medical services not related to the recipient's use of clozapine.

Related Services Which Are Reimbursed Separately from Clozapine Management

- White Blood Cell Count — The white blood cell count must be performed and billed by a Medicaid-certified laboratory to receive Wisconsin Medicaid reimbursement.
- Recipient Transportation — Recipient transportation to a physician's office is reimbursed in accordance with HFS 107.23, Wis. Admin. Code. Such transportation, when provided by a specialized medical vehicle (SMV), is not covered unless the recipient is certified for SMV services as described in the General Information chapter of this section. Recipient transportation by common carrier must be approved and paid for by the county agency responsible for Medicaid transportation services.

Billing for Clozapine Management

Wisconsin Medicaid reimburses a single fee for management services provided either once per calendar week (i.e., Sunday through Saturday) or once per two calendar weeks. Providers indicate a quantity of one for each billing period. For recipients who have weekly white blood cell counts, the billing period is one week. For recipients who have biweekly white blood cell counts, the billing period is two weeks.

Providers must bill clozapine management services on the national CMS 1500 claim form electronically, or on paper. For each billing period, only one provider per recipient may be reimbursed for one of the three clozapine management

Appendix 28
(Continued)

procedure codes listed below. The allowable procedure, type of service (TOS), and place of service (POS) codes are as follows:

Procedure	Description	TOS	POS
W8902	Clozapine Management — No face-to-face contact between client and clozapine management provider. Client may need a telephone reminder to assure the blood draw is done, but the client is able to get to the blood draw site.	1	0, 2, 3
W8903	Clozapine Management — Clozapine management provider does the blood draw at his or her office or at a site where multiple clients come.	1	0, 2, 3, 4
W8904	Clozapine Management — Clozapine management provider must go to a client's home or elsewhere to find client and draw blood (only one client per site).	1	0, 4

Allowable POS codes for clozapine management:
0 = Pharmacy
2 = Outpatient Hospital
3 = Doctor's Office
4 = Home

Appendix 29

Wisconsin Medicaid-Approved Temporomandibular Joint Surgery Procedure Codes and Temporomandibular Joint Evaluation Programs

Temporomandibular Joint Surgery Procedure Codes		
Procedure Code	**Description**	**Type of Service**
20910	Cartilage graft; costochondral	2, 7
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	2, 7, 8
21010	Arthrotomy, temporomandibular joint	2, 7
21050	Condylectomy, temporomandibular joint (separate procedure)	2, 7, 8
21060	Meniscectomy, partial or complete, temporomandibular joint (separate procedure)	2, 7, 8
21070	Coronoidectomy (separate procedure)	2, 7, 8
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	2, 7, 8
21242	Arthroplasty, temporomandibular joint, with allograft	2, 7, 8
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	2, 7, 8
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)	2, 7
29804	Arthroscopy, temporomandibular joint, surgical	2, 7, 8

Temporomandibular Joint Evaluation Programs

The following programs have been approved as multidisciplinary Temporomandibular Joint Evaluation Programs for Wisconsin Medicaid:

Medical College of Wisconsin
Oral and Maxillofacial Surgery
9200 W Wisconsin Ave
Milwaukee WI 53226
(414) 454-5760

Gundersen Clinic, Ltd.
1836 South Ave
LaCrosse WI 54601
(608) 782-7300, extension 2260

Oral and Maxillofacial Surgery Associates of Waukesha, Ltd
1111 Delafield St #321
Waukesha WI 53188
(414) 547-8665

Oral and Maxillofacial Surgery Associates of Green Bay SC
704 Webster Ave
Green Bay WI 54301
(920) 468-3400

University of Wisconsin Hospital and Clinics
600 Highland Ave
Madison WI 53792
(608) 263-7502

Appendix 30

Medicaid-Approved Organ Transplant Centers

Some out-of-state hospitals may not accept the Wisconsin Medicaid reimbursement rate established for transplants. Physicians and hospital discharge planners should refer transplant recipients only to hospitals that accept Wisconsin Medicaid reimbursement rates for transplants.

Transplant Type	Medicaid-Approved Centers
Heart Transplants	Children's Hospital of Wisconsin, Milwaukee, WI Fairview-University Medical Center (University of Minnesota Hospital and Clinics), Minneapolis, MN Froedtert Hospital, Milwaukee, WI Mayo Clinic (St. Mary's Hospital), Rochester, MN St. Luke's Medical Center, Milwaukee, WI University of Pittsburgh Medical Center, Pittsburgh, PA University of Wisconsin Hospital and Clinics, Madison, WI Other out-of-state hospitals approved by Medicare
Pancreatic Transplants	Fairview-University Medical Center (University of Minnesota Hospital and Clinics), Minneapolis, MN Froedtert Hospital, Milwaukee, WI Mayo Clinic (St. Mary's Hospital), Rochester, MN University of Pittsburgh Medical Center, Pittsburgh, PA University of Wisconsin Hospital and Clinics, Madison, WI
Liver Transplants	Children's Hospital of Wisconsin, Milwaukee, WI Fairview-University Medical Center (University of Minnesota Hospital and Clinics), Minneapolis, MN Froedtert Hospital, Milwaukee, WI Mayo Clinic (St. Mary's Hospital), Rochester, MN St. Luke's Medical Center, Milwaukee, WI University of Pittsburgh Medical Center, Pittsburgh, PA University of Wisconsin Hospital and Clinics, Madison, WI Other out-of-state hospitals approved by Medicare
Heart-Lung Transplants	Children's Hospital of Wisconsin, Milwaukee, WI Fairview-University Medical Center (University of Minnesota Hospital and Clinics), Minneapolis, MN Froedtert Hospital, Milwaukee, WI Mayo Clinic (St. Mary's Hospital), Rochester, MN University of Pittsburgh Medical Center, Pittsburgh, PA University of Wisconsin Hospital and Clinics, Madison, WI Other out-of-state hospitals approved by Medicare
Lung Transplants	Children's Hospital of Wisconsin, Milwaukee, WI Fairview-University Medical Center (University of Minnesota Hospital and Clinics), Minneapolis, MN Froedtert Hospital, Milwaukee, WI Mayo Clinic (St. Mary's Hospital), Rochester, MN University of Pittsburgh Medical Center, Pittsburgh, PA University of Wisconsin Hospital and Clinics, Madison, WI Other out-of-state hospitals approved by Medicare

Transplant Type	Medicaid-Approved Centers
Bone Marrow Transplants	Bone marrow transplants may be done at any Wisconsin Medicaid-certified facility with prior authorization.
Kidney Transplants	Kidney transplants may be done at any Medicare-approved facility. Prior authorization is not required for kidney transplants.

Appendix 31

Provider Certification of Emergency for Undocumented Aliens (for photocopying)

(A copy of the Provider Certification of Emergency for Undocumented Aliens form is located on the following pages.)

(This page was intentionally left blank.)

WISCONSIN MEDICAID
PROVIDER CERTIFICATION OF EMERGENCY FOR UNDOCUMENTED ALIENS

SERVICES FOR UNDOCUMENTED ALIENS

Under federal and state law, undocumented aliens (illegal aliens) are not eligible for Wisconsin Medicaid services except when those services are necessary for the treatment of an emergency medical condition. Use of this form is not mandatory, but by verifying that the service(s) provided was to treat an emergency medical condition (according to the federal definition), the provider is helping the county/ tribal social or human services department determine Wisconsin Medicaid eligibility for an undocumented alien.

Federal law states that illegal aliens are not eligible for Medicaid services except when those services are necessary for the treatment of an emergency medical condition. Federal law describes an emergency medical condition as follows:

> An emergency medical condition is a medical condition manifesting itself by acute symptoms of severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
>
> - Placing the patient's health in serious jeopardy.
> - Serious impairment to bodily functions.
> - Serious dysfunction of any bodily organ or part.
>
> Wisconsin Medicaid does not cover major organ transplants (e.g., heart, liver) for undocumented aliens pursuant to 42 USC s. 1396b(v)(2)(C).

MEDICAID ELIGIBILITY

Do not complete this form if the patient is already eligible for Wisconsin Medicaid. To determine whether a patient is a Medicaid recipient, contact the Wisconsin Medicaid Eligibility Verification System (EVS). For more information on the EVS, refer to the Provider Resources section of the All-Provider Handbook. Providers also have the option of calling Provider Services at (800) 947-9627 or (608) 221-9883 to determine the eligibility status of a patient.

Note: Your certification of 'emergency' does not guarantee Wisconsin Medicaid reimbursement.

RECIPIENT INFORMATION

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Continued on reverse

WISCONSIN MEDICAID

PROVIDER CERTIFICATION OF EMERGENCY FOR UNDOCUMENTED ALIENS

INSTRUCTIONS: The patient should take this form to the county/tribal social or human services office in his or her county of residence where the decision of eligibility is made. Wisconsin Medicaid advises providers to keep a copy for their records. Medicaid reimbursement for the emergency service is conditional on meeting all program rules, including medical necessity.

1. **Name — Patient**
   Enter the patient's last name, first name, and middle initial.
2. **Address — Patient**
   Enter the complete address (street, city, state, and ZIP code) of the patient's place of residence.
3. **Date of Birth — Patient**
   Enter the birth date of the patient.
4. **Social Security Number — Patient**
   This information is not required. Most undocumented aliens do not have Social Security numbers. It will only be used for the administration of Wisconsin Medicaid.
5. **Emergency Start Date**
   Enter the start date in MM/DD/YYYY format in which the patient was initially treated for the emergency condition.
6. **Emergency End Date**
   Enter the date in MM/DD/YYYY format in which the patient's condition was no longer considered an emergency condition (according to the federal definition), or the date in the future, in your judgement, the emergency condition will end.
7. **Name — Contact Person**
   Enter the name of the person who can verify the information provided on this form.
8. **Telephone Number — Contact Person**
   Enter the telephone number of the contact person, including area code.
9. **Name — Provider**
   Print the medical provider's name or the facility where treatment was provided.
10. **Signature — Physician**
    The form must be signed and dated by the performing physician or other individual who can verify that the patient was treated for an emergency condition according to the federal definition.
11. **Date Signed**
    Enter the date the form is signed.

1. Name — Patient	2. Address — Patient
3. Date of Birth — Patient	4. Social Security Number — Patient
5. Emergency Start Date	6. Emergency End Date
7. Name — Contact Person	8. Telephone Number — Contact Person
9. Name — Provider (Print)	
10. **SIGNATURE** — Physician	11. Date Signed

Appendix 32

Specialized Medical Vehicle Transportation Physician Certification (for photocopying)

(A copy of the Specialized Medical Vehicle Transportation Physician Certification is located on the following page.)

SMV Company name and address may be entered in the space below:

HFS 107.23 Wis. Admin. Code

SMV TRANSPORTATION
PHYSICIAN CERTIFICATION

All areas of this form must be completed by a physician, physician assistant, nurse midwife or nurse practitioner to justify the need for SMV transportation.

Please complete this form **only** if the Medicaid recipient is legally blind or disabled to the extent that he or she cannot safely use private vehicles or mass transit services. *Refer recipients who can safely travel in an automobile, taxi, or bus to the Medicaid transportation coordinator in their tribal agency or county social or human services department.*

I, _____ have evaluated _____ _____ _____

(Certifying Provider's name) (Recipient's Name) (Date of Birth) (Medicaid ID Number)

on _____ and certify that he or she requires the use of a specialized medical vehicle (SMV) for transportation to receive medical services and is *unable to manage available transportation by common carrier (e.g., car, taxi, bus).* The recipient has the following medical diagnoses/problems which justify the need for SMV transportation.

(Date)

Diagnosis/Problem	**ICD-9-CM Code**	**Describe how diagnosis/problem necessitates the need for SMV services**

Select one or some (but not all) of the following that describe the recipient's level of assistance requirements:

- A11 ☐ Cot/Stretcher (must have help)
- B11 ☐ Wheelchair
- C11 ☐ Cane/Crutches/Walker/Low Stamina/or Unsteady Gait (must have help)
- C21 ☐ Cane/Crutches/Walker/Low Stamina/or Unsteady Gait (moderate help)
- C31 ☐ Cane/Crutches/Walker/Low Stamina/or Unsteady Gait (minimal help)
- D11 ☐ Behavior/Cognitive Problem (must have help)
- D21 ☐ Behavior/Cognitive Problem (moderate help)
- D31 ☐ Behavior/Cognitive Problem (minimal help)
- G11 ☐ Hospital/Nursing Home Discharge

I certify the recipient's disability is indefinite or temporary (check one).

Indefinite ☐ (Certification must be renewed yearly.)

Temporary ☐

If temporary, specify expected number of days to resolution of condition/problem:

Days _____ (Maximum 90 days)

_____ _____ _____

(Signature) (Date) (UPIN or Medicaid Provider Number)

Appendix 33
Wisconsin Medicaid Newborn Report (for photocopying)

(A copy of the Newborn Report form is located on the following page.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1165 (Rev. 01/03)

WISCONSIN MEDICAID
NEWBORN REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

INSTRUCTIONS
1. Type or print clearly.
2. All requested information must be provided.
3. In multiple birth situations, a separate Newborn Report must be filled out for each birth.
4. For more information on newborn reporting, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883. Mail or fax completed forms to:

   Wisconsin Medicaid
   PO Box 6470
   Madison WI 53716
   Fax (608) 224-6318

SECTION I — HOSPITAL (OR OTHER PROVIDER) INFORMATION

Name — Hospital (or Other Provider)	Wisconsin Medicaid Provider Number (eight digits)
Name — Contact Person	Telephone Number — Contact Person ( )

SECTION II — NEWBORN INFORMATION

Name — Newborn (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)
Sex ❑ Female ❑ Male	Date of Death, if applicable (MM/DD/YYYY)

Multiple Births

❑ Yes ❑ No If yes, complete a form for each birth.

SECTION III — MOTHER INFORMATION

Name — Mother	Address (Street Address, City, State, and Zip Code)
Medicaid Identification Number — Mother	
Medicaid Identification Number — Case Head	

SECTION IV — AUTHORIZATION

This information is accurate to the best of my knowledge.

SIGNATURE — Hospital (or Other Provider) Representative	Date Signed

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Concurrent care

Evaluation and management (E&M) services provided by two or more physicians to a recipient during an inpatient hospital or nursing home stay.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and Wisconsin Medicaid.

Crossover Claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the U.S. Department of Health and Human Services (DHHS) assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of

infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Dual entitlee

A recipient who is eligible for both Wisconsin Medicaid and Medicare, either Medicare Part A, Part B, or both.

Emergency services

Those services which are necessary to prevent death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the provider's Remittance and Status (R/S) Report and informs Medicaid providers of the status or action taken on their claims.

Established patient

A patient who has received professional services from the physician or from another physician of the same specialty and belonging to the same group practice, within the past three years.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCFA

Health Care Financing Administration. *Please see the definition under CMS.*

HCPCS

Health Care Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes *Current Procedural Terminology* (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, to supplement CPT codes. (Formerly known as "HCFA Common Procedure Coding System.")

HealthCheck

Program which provides Medicaid-eligible children under age 21 with regular health screenings.

HPSA

Health Personnel Shortage Area. A medically underserved area in Wisconsin.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
b) Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
   2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
   3. Is appropriate with regard to generally accepted standards of medical practice;
   4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
   6. Is not duplicative with respect to other services being provided to the recipient;
   7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
   8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
   9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

New patient

A patient who is new to the provider and whose medical and administrative records need to be established. A new patient has not received professional services from either the physician or group practice within the past three years.

On-site supervision

The supervising physician is in the same building in which services are being provided and is immediately available for consultation or, in the case of emergencies, for direct intervention.

PA

Prior authorization. The written authorization issued by the Department of Health and Family Services (DHFS) to a provider prior to the provision of a service.

POS

Place of service. A single-digit code which identifies the place where the service was performed.

QMB Only

Qualified Medicare Beneficiary under the Medicare Catastrophic Health Act. A QMB-only recipient is only eligible for the payment of the coinsurance and the deductible for a Medicare-allowed claim.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform the provider regarding the processing of the provider's claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

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